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The New Conception of Tuberculosis Infection

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SO much has been written regarding the many and varied aspects of tuberculosis, that it is not likely that anything particularly new can be said about the disease, yet from the great volume of research in recent years, we are discovering newer viewpoints, even of old beliefs about it, and it is of the utmost importance that from time to time we review these changing viewpoints, if we are to make the most of our responsibilities and opportunities for the prevention and cure of the Great White Plague. In no instance is this more true than in the whole problem of tuberculosis infection, particularly as it relates to childhood. So important are these newer conceptions of infection in childhood, and the methods of prevention of subsequent disease, that *until our conception of tuberculosis infection shall have radically changed and come more into line with the newer teachings of scientific medical research, a large part of our efforts in the tuberculosis campaign will be misdirected and wasted.*

It is, therefore, the purpose of the writer to discuss our newer knowledge with reference to tuberculosis infection in childhood; the clinical aspects of tuberculous disease in childhood; and a program for the recognition and treatment of childhood tuberculosis.

Universal Tuberculosis Infection

SINCE 1882, when Koch's discovery of the tubercle bacillus established for all people what had previously been only a suspicion in the minds of a few students; namely, that tuberculosis is a germ disease caused by the tubercle bacillus, the world has gone through a period of phthisiophobia or morbid dread of this disease. Following this discovery a campaign was begun for the destruction of the tubercle bacillus, and the segregation and isolation of those afflicted with tuberculosis. It was believed at that time that all—*adults and children*—were equally open to tuberculosis infection; and the fear of infection, together with the responsibility resting upon the community to provide for the cure and the humane care of the tuberculous, gave birth to the world-wide movement for the establishment of sanatoria and tuberculosis hospitals.

Later, with the announcement by Dr. Von Pirquet of his tuberculin test, which demonstrated the presence or absence of tuberculosis infection, and his subsequent discovery that practically all children up to 16 years of age are infected with tuberculosis (90 per cent positive reactions), the significance of infection began to be disregarded, particularly in so far as it

was indicated by a positive tuberculin reaction. This belief in almost universal infection was widely disseminated, and it was quite generally accepted until recent years.

Far Lessened Incidence of Infection

EXTENSIVE surveys in recent years, however, indicate a far less incidence of tuberculosis infection. Drs. Chadwick and Zachs in a recent paper entitled, "The Incidence of Tuberculosis Infection in Children," give some interesting statistics on the tuberculin testing of thousands of children in the ten-year program of the Massachusetts State Department of Health. They note that the percentage of positive reactors shows a surprising variation in different districts throughout the state. In some sections this percentage among the school children was as low as 16, and in others it rose as high as 60. Up to September 1, 1928, a total of 73,863 children had been tested. Of these 20,648, or 27 per cent, presented a positive reaction. A total of 23,376 of these children were x-rayed, and 2,169 presented positive x-ray findings—2,082 being classified as hilus tuberculosis (tuberculosis of the tracheo-bronchial glands), and 87 being diagnosed as pulmonary tuberculosis.

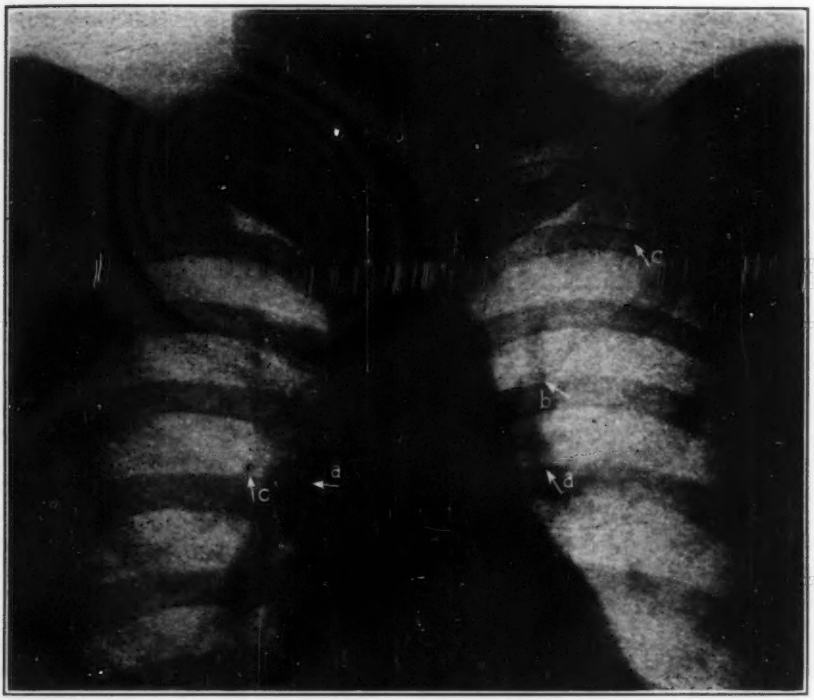
In a paper, "A Report of the Study of 25,048 School Children for Tuberculosis," by Dr. P. P. McCain of the North Carolina State Sanatorium, we find these significant figures: Out of 25,048 children tested, slightly over 22 per cent showed a positive tuberculin reaction. Slightly over 7 per cent of the positive reactors were diagnosed as positive tuberculosis cases. The colored children showed both a higher percentage of tuberculin reactors, 27.41 per cent, as compared with 22.07 per cent for the whites; and a higher incidence of demonstrable tuberculosis, 3.21 per cent of the total number tested as compared with 1.53 for the whites.

Extensive research work done in New York City by the Health Department shows that the positive reactions to tuberculin are becoming less and less in number, and according to these findings it appears that slightly less than 40 per cent of the children in New York are infected with tuberculosis germs.

The figures given above are the results of surveys of children of school age in general and not of special groups. In a series of examinations of 1,095 "contact" and seriously malnourished children with suspicious signs in the chest made by the author in the schools and tuberculosis clinic centers in a New Hampshire city 43.1 presented a positive tuberculin reaction.

In connection with the figures of Von Pirquet and Hamburger, and other observers in Europe, who have advanced the theory of almost universal infection with tuberculosis, it must be remembered that the studies were made over thirty years ago in countries (Austria and Germany) where tuberculosis was a prevalent disease.

The tuberculin test, as well as other means of diagnosis, have established the fact that the newborn infant, even of a tuberculous parent, is free from tuberculosis. Present figures indicate that during the first year of life about 10 per cent of all children, including those of healthy families, become infected. After this age, the proportion gradually rises, so that by 16 years of age approximately one-fourth would show a positive tuberculin reaction, and it is reasonable to suppose that approximately one-third of all adult individuals are infected.



JUVENILE (HILUM) TUBERCULOSIS

Hilum presents well defined circular gland areas (a). Note "beading" (b). Scattered calcium nodules (c). (Interpretation of x-ray plate by J. S. Bragg, M.D., Roentgenologist, Manchester, N. H.)

These figures of present incidence of tuberculosis infection, as shown by tuberculin testing, indicate that there has been a tremendous reduction in the number of people infected within the last 30 or 40 years. This reduction is entirely consistent, when one considers the tremendous decline in the tuberculosis death rate and in the number of the most prolific spreaders of the infection—the advanced cases. These figures are convincing proof, with other data, of the effectiveness of the entire anti-tuberculosis campaign.

Let it be said here, for fear of misunderstanding, that tuberculosis infection simply means the presence of tubercle bacilli somewhere in the body. It does not mean the presence of tuberculosis—the disease caused by the multiplication and elaboration of these microörganisms. *It should also be understood that a positive reaction to tuberculin is generally accepted as a proof of infection with tuberculosis whether dormant or quiescent or active.* It is now estimated that approximately one per cent of the population ultimately present active tuberculous disease and therefore need radical treatment.

Childhood Tuberculosis Infection

IN 1903, Dr. Von Behring announced his belief that tuberculosis infection occurs during infancy and,

as a rule, because of the extremely chronic nature of the infection, remains dormant until the early adult years are reached. He pointed out that, in addition to infection, it required the lowering of the powers of body resistance either at puberty, or childbirth, or as a result of after-effects of acute disease, or under-nutrition, or prolonged physical and mental strain, or bad working, living and housing conditions, dissipations, etc., to permit the infection to progress into active disease.

Of recent years accumulating evidence substantiates this belief, and warrants the conclusion that nearly all tuberculosis infection is acquired in childhood; that practically all active tuberculosis in adults originates from this childhood infection, and that adults themselves are practically immune to infection.

Childhood Tuberculosis Disease

THAT a certain number of children infected developed active disease in infancy and early childhood to which many succumbed, had been known, but the diagnosis of tuberculosis in childhood had been almost wholly restricted to the first few years of life, until recent exhaustive research and demonstrations, through the examination of thousands of children, proved that the early beginnings of the disease, as well as of infection, could be shown to exist even prior to the development of actual tuberculous disease in adult life.

First, let me say, however, that tuberculosis as we ordinarily know it, *i.e.*, lung tuberculosis, is uncommon before twelve years of age. It is not until fourteen years of age that we begin to find the typical manifestations of the disease as we see it in the adult. For this reason the death rate from tuberculosis is amazingly low in the age period from four to fourteen years. After this period it begins to rise, so that from the twentieth to the thirty-fifth year, it is at its peak.

We find, therefore, that for practical purposes we are dealing with three distinct manifestations or types of the disease in childhood, varying according to age as follows: infantile, juvenile, and adult.

Infantile Tuberculosis

THIS type occurs usually under four years of age. It is a generalized process involving frequently all organs of the body, and ending in meningitis, peritonitis, etc. The course of the disease is acute, rapidly progressive, and fatal, with high temperature, prostration, and rapid emaciation. The condition is, of course, serious and the *prognosis is distinctly unfavorable. Treatment is practically without avail and naturally is distinctly along generally supportive lines.*

The acute and rapid nature of the disease is in all probability due to the fact that practically no resistance has been developed to the infection, and that the dosage of infection is usually large in amount.

The diagnosis is made by:

(a) The history of infection—usually there has been an intimate contact in the home from a tuberculous patient.
(b) The acute course of the disease.
(c) The involvement of the various organs.
(d) The signs of acute activity in the lungs.

Juvenile Tuberculosis

THIS form of the disease, variously termed tracheobronchial, juvenile, and hilum tuberculosis, occurs between five and twelve years of age. It is a localized process in the glands at the root of the lung, a bronchial glandular tuberculosis or hilus tuberculosis. This type is often called pretuberculous or latent tuberculosis.

The course of the disease is benign, the great majority of the cases curing spontaneously with calcification of the glands; *but a small percentage develop a slowly progressive inflammatory process, culminating in caseation and dissemination of the germs and pus into the adjacent lung tissue, particularly if the patient is untreated, or the resistance is poor and the environment unfavorable.*

In this type, a definite degree of immunity has been established, and as indicated above, only a small percentage will show a failure of immunity or resistance, and consequent disease, and require preventive and curative treatment.

The development of a juvenile tuberculosis condition occurs about as follows: the tuberculosis germs are almost always carried to the periphery of the lung and infection takes place in the lung cells. As the germs multiply they pass out of the inflammatory area resulting from the presence of the germs and are caught up by the lymph channels, whose valves, pointing towards the hilum or root of the lung, force them to the tracheobronchial glands. Under favorable conditions these glands, which consist of a firm fibrous substance, constitute an effective barrier to the further progress of the germs. If the resistance is good, the glands become calcified and choke up the infection. However, the resistance may be poor, for many and various reasons, and the bacilli may multiply and grow in the glands, and one of the characteristics of this condition is that a lesion in the tracheobronchial glands at the hilus or root of the lung is usually more extensive than in the first focus at the periphery of the lung. The latter is usually about the size of a pea, while the condition in the glands at the root of the lung may be larger than an almond.

There are no characteristic symptoms of juvenile tuberculosis, and the condition may be found in apparently normal children. The following evidences are the most frequently noted:

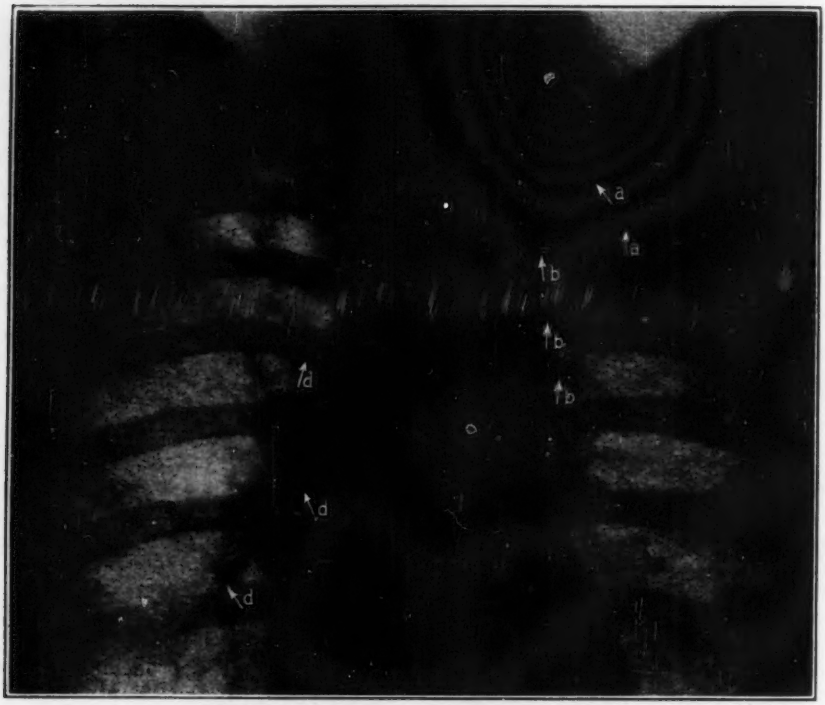
Undernourishment, an occasional loss of weight, a frequent failure to grow and gain weight, poor appetite, fatigue, a lack of energy, irritability, or retarded recovery from some other disease, such as measles, whooping cough, or influenza, without any complications to account for the delay.

A slight degree of temperature is frequently present. The pulse is likely to be a little rapid. There may be a tendency to frequent and protracted colds. Cough usually is not present and, if present, it is, as a rule, unaccompanied by expectoration. Shortness of breath is rarely present, except in those few cases in which the glands are large enough to exert pressure on the tracheobronchial tree.

The symptoms above enumerated are more particularly present when there is a definite inflammatory process in the tracheobronchial glands, and if found in connection with positive tuberculin reaction, physical signs, and x-ray evidence of enlargement and thickening of the tracheobronchial glands, they are an indication of the need for prompt treatment. These are the type of cases which, if neglected, develop into the pulmonary or adult type of tuberculosis, in which the lung tissue is invaded.

The prognosis in the great majority of juvenile or hilus cases is favorable. A good degree of immunity is usually built up, and the matter for concern is those cases showing failure of immunity or resistance—the class of cases with symptoms and signs as indicated above.

Even here the condition is essentially benign, and if proper treatment is instituted, practically all children having tracheobronchial tuberculosis and especially those over two years of



ADULT TYPE OF CHILDHOOD TUBERCULOSIS

Showing typical extention from hilum and involvement of lung tissue. Parenchyma of first and second interspaces show extensive mottling extending from periphery toward hilum (a). Fluffy areas with increased density in center are seen along course of vertebral root shadows (b). Calcium nodule (c). Artefacts (d). Primary focus not identified. (Interpretation of x-ray plate by J. S. Bragg, M.D., Roentgenologist, Manchester, N. H.)

age, will be arrested or entirely cured. Treatment may be carried out in the home, in health camps, preventoria, or sanatoria, depending upon the needs in each case. The cure is, as a rule, easy because the tuberculous infection and inflammatory process are as yet retained in the fibrous tissues of the bronchial glands, and the tendency is toward calcification.

The diagnosis is not easy. The points in the diagnosis are:

(a) The symptoms as above enumerated.
(b) The physical signs at the hilus and a dullness along the spinal column overlying the branching out of the main bronchus.
(c) The positive tuberculin test.
(d) X-ray of chest showing enlargement or thickening of the glands about the hilum or root of the lung.

Adult Tuberculosis

THIS type occurs usually from twelve or fourteen years of age up to adult life. It is a lung process with involvement of the lung tissue—distinctly a pulmonary tuberculosis with, of course, accompanying bronchial-glandular adenitis. There has been definite failure of immunity or resistance, and the disease has now broken through the fibrous barrier of the bronchial glands into the spongy lung

tissue. The disease is now no longer incipient—but in the opinion of tuberculosis experts, it is advanced.

The course of the disease is usually chronic, as in the adult type, some cases requiring treatment and care for a period of months and even years.

The symptoms are approximately the same as in the adults:

(a) Loss of weight and strength.
(b) Afternoon temperature.
(c) Sweats and chills.
(d) Cough and expectoration.
(e) Bloodspitting and hemorrhage.
(f) Tubercle bacilli in sputum in some of the cases.

The condition is serious and the prognosis is guarded. Prolonged treatment saves a certain percentage of these cases. Undoubtedly some spontaneous recoveries occur without treatment even in this type, but the percentage is small. Treatment can best be secured in a sanatorium.

The diagnosis of this type is comparatively easy. The points in the diagnosis are the same as those for the adult with pulmonary tuberculosis.

(a) Symptoms as enumerated above.
(b) Signs in lungs—dullness, diminished breathing, and crepitation.
(c) X-ray plate of chest showing mottling in the lung fields.
(d) Tubercle bacilli in sputum in some cases.

The Tuberculin Test

A POSITIVE tuberculin test is the first requirement for a diagnosis of clinical tuberculosis in childhood. The intracutaneous test is easily given and more certain than others. The positive tuberculin test only indicates tuberculous infection, the presence of *live* tubercle bacilli somewhere in the body. One of the great students of tuberculosis, Allen K. Krause, has shown that a positive reaction will become negative when the germs die out.

If the test is positive the child may or may not have tuberculous disease. Further examination should, of course, be resorted to for the eliciting of signs in the chest. An x-ray of the chest should be taken. The positive tuberculin test having established that infection is present, the resultant examinations should prove the presence or absence of tuberculous disease.

If the tuberculin test is negative, there is no tuberculous disease present—in fact, not even tuberculous infection. It is evident, therefore, that a negative test is exceedingly valuable information. The tuberculin test is negative in the great majority of children tested—in fact, only from one-fourth to one-third presenting a positive reaction. Too much emphasis cannot be laid upon the importance of a test which is so easily and quickly given, and which in so large a proportion of cases will settle the diagnosis so far as presence or absence of tuberculosis infection is concerned.

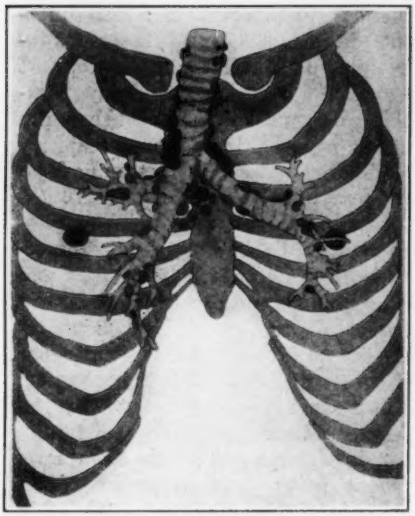
It is also interesting to note that the degree of reaction to the tuberculin test is of some value—*the stronger reactions being more suggestive of the presence of clinical disease.* The children presenting the strong tuberculin reactions most frequently show active clinical disease. This has been noted by other observers, particularly Opie and McPhedran and McCain.

The X-Ray of Chest

IT is only by the x-ray that tracheobronchial (juvenile or incipient hilus) tuberculosis can be definitely demonstrated. A diagnosis of suspicious hilus tuberculosis may be made upon symptoms, signs, and positive tuberculin reaction. When the lesions contain calcium, the primary focus may be seen somewhere around the surface of the lung as a density about the size of a pea; and the tracheobronchial nodes, which drain the lymph from the area of this focus, will

appear as densities which are usually larger than the first focus. These densities appear about the hilus or bifurcation of the trachea.

The densities may be of any shape and degree depending upon the extent of the involvement and the amount of calcium they contain.



A DIAGRAM OF THE BONY FRAMEWORK OF THE CHEST

Showing the bifurcation of the trachea or hilum and the location of the tracheobronchial glands, which are the seat of Juvenile Tuberculosis.

It is important to remember that while the x-ray evidence of thickened and enlarged glands at the hilus is necessary for a diagnosis of incipient hilus tuberculosis, the diagnosis does not rest upon the x-ray alone, or upon any other phase of the examination, but upon the proper correlation of all the information obtainable, such as, the symptoms, the physical examination signs, and the positive tuberculin reaction. In fact in very suspicious cases, with suggestive symptoms, which cannot be accounted for by any other condition, and more especially if the tuberculin reaction is strongly positive, a probable diagnosis of hilus tuberculosis should be made, even though the x-ray is negative. This should be done, especially, if a history of prolonged exposure to open or active tuberculosis is also present. It must also be kept in mind that x-ray evidence of enlarged and thickened tracheobronchial glands is not sufficient for a diagnosis, unless accompanied by a positive tuberculin reaction and suspicious symptoms.

(To be continued)

Blood Transfusion To Be Regulated

INVESTIGATIONS carried on by the Department of Health in New York City in coöperation with the Public Health Committee of the Academy of Medicine indicate the necessity of prompt action to curb dangerous and almost unbelievable abuses which have developed in connection with blood transfusion.

Between seven and eight thousand transfusions are performed in New York City annually and there are about two thousand individuals in this city listed, in so-called "blood agencies," who derive an income from acting as blood donors. Some of these have been found suffering from transmissible infectious diseases.

In order to have available a list of healthy donors, the Department of Health plans to regulate the practice of transfusion by prohibiting it except when carried out in accordance with the provisions of the Sanitary Code and under rules and regulations to be adopted by the Board of Health. The plan proposed is as follows:

An official list of blood donors will be established. Each prospective donor will be required to submit to a careful medical examination, including a Wassermann's test and tests to determine exactly the classification of his blood. If found to be a suitable donor, his name, address and blood classification will be entered on the official list and he will receive a passbook, similar to a government passport, in which his blood classification is clearly shown and in which a weekly health visa will be entered. The passbook will contain the donor's photograph in order to avoid substitution.—From the *Weekly Bulletin of the New York City Department of Health.*

Group Nursing in Psychiatry

BERNADETTE A. MULLIN, R.N.

The nursing in a private ward of a psychiatric division of a hospital has a double difficulty, that of the demands and needs of the individual patients and that of creating at the same time a reasonable socialization. The customary private nursing is apt to give the patient a sense of owning the special nurse and there is apt to develop an aloofness from group responsibility and group life. It is perfectly natural that a private patient should want to be private and to have personal attention. But in the long run, the socialization of the patient and the utilization of the organized hospital resources in the daily life and in the philosophy of the use of time are most important items. For the nurses, too, the plan has great advantages. It keeps up a preparedness to meet a wide range of problems and to keep active with many resources.—ADOLF MEYER, M.D. *Director, The Henry Phipps Psychiatric Clinic.*

THE study of economics is today commanding the attention of all branches of activity and hospitals from all over the country are uniting in the discussion of plans toward the easement and adjustment of hospitalization costs to the average patient through group nursing as opposed to special nursing. While there is no question as to the necessity and advisability of this effort toward financial saving, yet there is another aspect which should be considered along with the economic, and that is the therapeutic advantages to be gained thereby.

The Henry Phipps Psychiatric Clinic at the Johns Hopkins Hospital has evolved a plan which appears, after a twelve-month trial, to be carrying on with a commendable measure of success a system which is demonstrating both economical and therapeutic advantages and progress. As the result of the carefully-thought-out and detailed plan of our Director, Dr. Adolf Meyer, to whom all credit is given for its origin and generous support and for guidance toward its fulfillment, we have introduced into our private wards a group nurse system which is designed especially for the care of mental patients.

The underlying principle of this system is to combat, in this class of patients especially, the tendency to utter dependence upon the special nurse assigned to the patient as well as the complete isolation of the patient in relation to all others than his particular nurse. The former system was certainly not helpful in all respects to the patient nor was it in accord with the order of therapeutics prescribed in our work.

Under this plan, each private ward, comprising eight patients, is cared for by a head nurse with four assistant graduate nurses. One other nurse divides her time between two such wards. Each Monday the hours are changed, and are maintained for that week. Each nurse is assigned to certain patients for the general care and changed once a week in order to bring about new contacts of nurses. Each day is planned in details of hours of occupation and recreation for the group of patients with the idea of stimulation and relaxation. There is the problem which requires much concentration, of tactfully avoiding the clash and irritation of personalities and the insistent demand for individual attention by the patient who feels himself helpless and dependent. A plan of a week's hours follows on page 1288.

The nurses have enjoyed their work and have considered it a worthwhile experience, which is evidenced by the fact that during the year we have engaged twenty-one nurses, four of whom are returning for the second

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Head Nurse—1.....	7–1; 4–7	7–1; 3–6	7–1; 3–6	7–1	7–1; 3–6	7–1; 3–6	7–1
Nurse—2.....	8–1; 3–7	8–12; 2–7	8–1; 3–7	8–1; 2–6	7–1	8–12; 3–7	7–1
Nurse—3.....	7–12; 3–7	8–11; 1–7	7–1	7–12; 3–7	8–12; 2–7	8–11; 1–7	1–7
Nurse—4.....	7–10; 1–7	7–1	8–11; 1–7	8–11; 1–7	8–11; 1–7	7–10	
Night Nurse.....	7–7	7–7	7–7	7–7	7–7	7–7	1–7

year, including the two head nurses, and the duration of time for the remainder has been from one to eight months.

There can be no thought of undervaluing special nursing in certain cases and our plan is devised to care for these when needed, but among mental patients there are many types, such as the one with tendency to seclusiveness and introspection and the self-centered who have lost their hold and normal interest in their surroundings, who are directly benefited by the broader interests and more varied contacts offered through the group system.

It is essential that the nurses become thoroughly acquainted with the condition and progress of their patients by close accord with the physician in charge and by routine weekly conferences where problems may be discussed as well as discourses given on Psychiatry to broaden the nurses' knowledge of the subject in general.

And now, after a twelve-months' period of trial, we are convinced that this plan of group nursing, carefully outlined and adapted to the particular situation, will not only prove itself in an increasing degree to be a logical and helpful solution from the point of view of economics, but will also offer in the field of therapeutics an immeasurable possibility of balanced development and progress.

Kansas Has Combined Liberal Arts and Nursing Course

AT the meeting of the faculty of the College of Liberal Arts and Sciences of the University of Kansas on Saturday, June 8, it was voted to adopt the Combined Liberal Arts and Nursing Course as outlined by the committee appointed for that purpose. The course had been previously approved by the Administrative Committee of the Medical School.

This course will require three years (six semesters) of work at the University of Kansas, Lawrence, and twenty-four months at the Bell Memorial Hospital, Kansas City. Six weeks' vacation will be allowed at the hospital. After the student has satisfactorily finished her college and hospital work she will be given a Bachelor of Science degree and her diploma in nursing.

Requirements for Graduation

(From the *Bulletin of the University of Kansas*)

A Bachelor of Science degree is granted by the University of Kansas to those young women of good moral character who have met the following requirements:

1. Satisfactory completion of 90 hours college work.
2. Completion of two years' residence in the School of Nursing.
3. Satisfactory completion of theoretical and practical work in the School of Nursing.
4. Payment of diploma fee of $10.
5. Demonstration of moral, mental and physical fitness for the profession of nursing.

Endoscopy

Part II

NORA L. ZUFALL, R.N.

ESOPHAGOSCOPY is the examination of the esophagus with the aid of an esophagoscope. The most common indication for an esophagoscopy is dysphagia. The following are frequent causes of dysphagia:

(1) Foreign body in the esophagus, (2) esophagitis, (3) cicatrical stenosis, (4) cancer of the esophagus, (5) Preventriculosis, so called "cardio-spasm," (6) diverticulum of the esophagus.

Foreign body in the esophagus will produce symptoms dependent upon the size, shape, and location of the foreign body. If the foreign body lodges high up in the esophagus, dyspnea may develop, due to the pressure on the trachea, and the patient is usually unable to swallow anything, thus causing an overflow of saliva. These symptoms disappear when the foreign body is removed. If the foreign body has lodged lower down in the esophagus, it may obstruct sufficiently to prevent swallowing of solid foods or liquids, although in a normal esophagus it usually causes only partial obstruction. It is well to remember that a foreign body in the air or food passages will eventually cause death unless removed. After a foreign body has been removed from the esophagus, the patient should be kept on sterile liquids as long as is necessary. Bismuth subnitrate, given dry on the tongue every three or four hours, has been found quite beneficial.

Esophagitis may be either acute or chronic. In a case of acute esophagitis it is well for the patient to remain in bed, to have sterile liquids by mouth, and bismuth subnitrate dry on the tongue. Bismuth subnitrate given dry has a tendency to coat the esophageal wall, thereby acting as an antiseptic directly to the esophagus, and also as a protective coating. In all cases of dysphagia the mouth must be kept scrupulously clean but this is particularly necessary in cases of esophagitis. In some cases medication is applied through the esophagoscope.

Cicatrical stenosis is a narrowing of the lumen of the esophagus caused by the formation of scar tissue. While this may follow certain acute illnesses, such as typhoid fever, the most common cause is the swallowing of a strong alkali or acid, therefore most cases of cicatrical stenosis of the esophagus are preventable. As lye and similar strong alkalies are commonly used for cleaning purposes, they are the chief offenders. The mother or some other person may dissolve lye in a cup and fail to rinse the cup before putting it down, or may even leave some of the solution in the cup. A child comes around a little later and drinks from the cup. As a result the lips, mouth and esophagus are burned. The patient may die in a very short time from edema of the glottis, or may recover from the acute condition and an esophageal stenosis may follow the healing of the burns. If the esophageal lumen remains large enough for the patient to get sufficient nourishment, the esophagus may be dilated with silk web bougies mounted on metal and used through the esophagoscope. The results are usually very satisfactory if dilatation is started early.

In many cases the lumen of the esophagus is so narrow that the

patient is unable to swallow his own saliva. In a case of this kind a gastrostomy must be done in order to save the patient's life. As soon as the gastrostomy wound and the esophagus have healed sufficiently, retrograde dilatation of the esophagus is started. Dilatation with the Tucker retrograde bougies has proved to be a very effective method of treatment in these cases. The present trend is to teach preventive medicine and not only the cure of disease. In this one should include the dangers of lye and other caustics which can as easily prove fatal, when taken internally, as any of the most heroic drugs. It takes only a minute for a child to swallow a strong caustic which has been left within its reach, but it will take months, and many times years, of treatment to dilate the esophagus sufficiently to enable the patient to be without a gastrostomy feeding tube.

Cancer of the esophagus is a fairly common condition and can be definitely diagnosed only by direct inspection, and possibly biopsy. Up to the present time cancer of the esophagus has best been treated by deep radiotherapy. If the cancerous growth is large enough to prevent the intake of sufficient nourishment, a gastrostomy is usually performed. The prognosis in cases of cancer of the esophagus is not good at present but it is impossible to know future developments in treatment. While the art of practicing medicine is as old as our knowledge of history, the science of medicine is yet young in its possibilities.

Preventriculosis is due to the dilatation of the esophagus, and is usually characterized by food collecting in the esophagus. As stale food may remain in the esophagus for days at a time, the condition is frequently accompanied by esophagitis. During esophagoscopic inspection or treatment, as much as 300 c.c. of stale food and secretion has been aspirated from the esophagus. The treatment consists chiefly of dilating the esophagus below the already dilated portion, proper diet, and keeping the esophagus free from stale food.

Diverticulum of the esophagus is a hernia of the esophagus, and frequently requires surgical intervention. At the time of operation a small feeding tube may be passed into the stomach and allowed to remain there for a few days, thereby giving the esophagus a complete rest. After the operation, the patient should be given sterile food and water until the esophagus has healed.

Retrograde Esophagoscopy

Retrograde esophagoscopy is the examination of the esophagus with the aid of an esophagoscope passed through a gastrostomy opening. In cases of stricture of the esophagus which require gastrostomy, the stricture will not permit an esophagoscope to pass it through the mouth. In order to examine the lower esophagus in these cases, an esophagoscope is inserted through the gastrostomy opening.

Retrograde dilatation of the esophagus can be carried out only after a gastrostomy has been performed, and after a continuous string has been passed through the esophagus. This "string" is surgeon's white, twisted silk, about No. 14. The patient is sometimes able to swallow the string, although more often a peroral esophagoscopy and retrograde esophagoscopy are necessary. When the two esophagoscopes are brought as near together as possible, a small esophageal bougie to which the silk has been securely tied is passed through the retrograde esophagoscope to a point at which the silk can be grasped by an esophagoscopic forcep. This forcep is passed

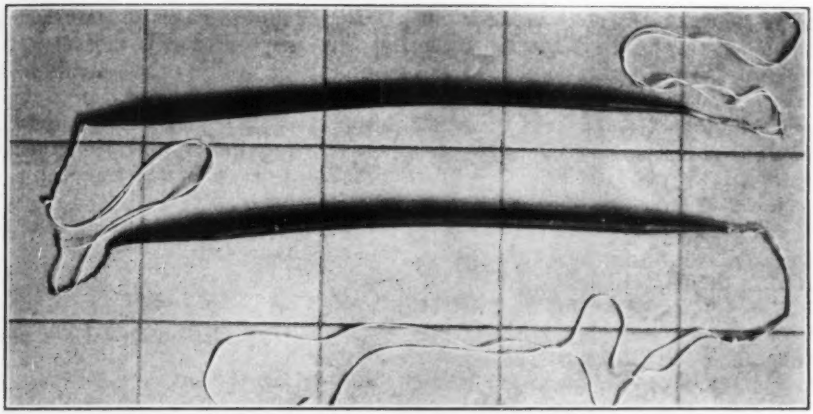


FIGURE 2. TUCKER RETROGRADE BOUGIES

down through the esophagoscope which has been inserted through the mouth. One end of the silk is then brought out through the mouth, and the other through the gastrostomy opening. When the esophagoscopes are removed, great care should be taken that neither end of the string is lost. One end of the string is brought out through the nose and tied securely to the end which comes out of the gastrostomy, thus making a continuous string through the esophagus. The string is fastened back of the ear with a small piece of adhesive. The patient is now ready for retrograde dilatation.

Articles needed:

Tucker retrograde bougies of desired sizes
3 yards surgeon's white, twisted silk, No. 14
3 tongue depressors
1 Jackson pillar retractor
1 pair scissors
1 package of sterile dressings
2 sterile covers
Adhesive tape ½ inch wide
Sterile vaseline
Sterile duplicate feeding tube.

Preparation of patient. The patient should have no food or water for at least five hours previous to the dilatation. There should be a check up on his general physical condition to determine whether or not there are any contraindications to the treatment. When the patient is brought to the treatment room, the feeding tube is removed and the abdomen surrounded by sterile linen.

Procedure. The Tucker retrograde bougies are made of soft rubber and have a continuous string through them. The more gradually tapering end should enter the gastrostomy opening first. Usually three bougies of increasing size are used at each treatment. These bougies should be securely fastened together with surgeon's silk, as shown in figure 2. A piece of silk, long enough to go through the entire esophagus, should be attached to the largest bougie, so that if the bougie will not pass through the stricture it can be brought back through the gastrostomy opening. The continuous string through the esophagus is cut near the gastrostomy opening and securely tied to the smallest bougie, and also a fresh string. The operator brings the old string out of the mouth, being careful not to pull it out of the nose. By making traction on this string, the

fresh string and bougies are brought up through the esophagus, out the mouth, the old string is cut off the bougie, and the fresh string is brought out through the nose. The two ends of the fresh string are securely tied together, a duplicate sterile feeding tube is inserted, and dressings applied in the usual manner. The patient may be given a feeding as soon as he desires it after the dilatation.

Care of bougies. After use the bougies are thoroughly washed with soap and water, then put in a 1 per cent solution of lysol for about fifteen minutes. They are then rinsed with sterile water and allowed to dry. When sufficiently dry the surgeon's silk, which has been used to connect the bougies, is removed. Great care should be taken not to cut the continuous string which goes through the bougie, thereby rendering the bougie useless.

Tracheotomy

Tracheotomy means cutting into the trachea. The chief indication for a tracheotomy is laryngeal dyspnea. In bronchoscopic work, one of the things most necessary for a nurse to know is the symptoms of dangerous dyspnea. Because of their close relationship to the larynx, whether it be an esophageal, laryngeal or bronchial case, sudden dyspnea may develop and may prove fatal unless recognized early.

Physical signs[1] of urgent dyspnea are

1. Indrawing of the suprasternal notch
2. Indrawing around the clavicles
3. Indrawing of the intercostal spaces
4. Restlessness
5. Choking and waking as soon as the aid of the voluntary respiratory muscles ceases, in falling to sleep
6. Cyanosis is a dangerously late symptom.

[1] Jackson, Dr. Chevalier, Bronchoscopy and Esophagoscopy, 1927, page 382, Chapter XXXVIII.

By the time cyanosis appears, which is the symptom one is most apt to think of when dyspnea is mentioned, the patient is so worn out from lack of sleep and the voluntary muscular activity required in breathing, that death may occur before a tracheotomy can be done.

Preparing for a tracheotomy, the following are needed:

Sterile linen for draping patient
Sterile gloves
Sand pillow to put under patient's shoulders
1 scalpel
1 curved, blunt bistoury
2 Jackson's tracheotomic retractors
1 Trousseau's dilator
6 Jackson's curved hemostats
1 10 c. c. Record syringe with two needles
6 suture needles-full curved
6 tubes catgut—plain No. 1
1 needle holder
6 Jackson's tracheotomy tubes, sizes 1-2-3-4-5-6
1 Jackson's copper tracheotomic aspirating tube, with Tucker valve
1 laryngeal aspirator for the mouth
1 package of gauze sponges
1 package of gauze dressings 4 x 4
1 pair tracheotomy tapes
Sterile vaseline
1 suction pump
1 oxygen tank
Alcoholic iodine 5 per cent
Alcohol 95 per cent
Sterile water
Bichloride of mercury 1–10,000 solution
Novocain ½ per cent solution, or other local anesthetic.

The patient is placed on the table with a sand pillow under his shoulders and the neck extended. As a local anesthetic is used, the patient should be properly restrained. When the field of operation is prepared with iodine and alcohol, great care should be taken to remove the excess iodine. Bichloride of mercury, 1–10,000, is used on the tracheotomy dressing and if combined with iodine it will burn the skin.

Before the trachea is incised, a tracheotomy tube of correct size

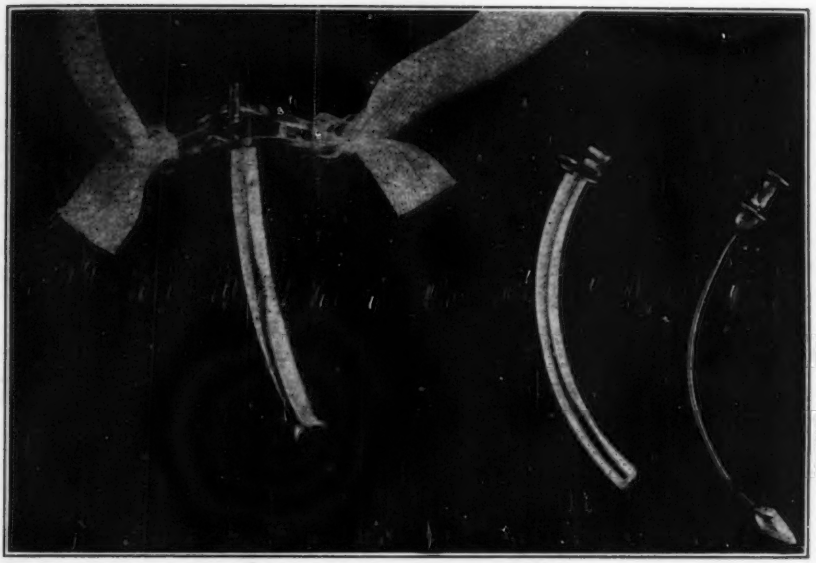


FIGURE 3. TRACHEOTOMY TUBE

should be ready for insertion. A complete tracheotomy tube consists of an outer cannula, an inner cannula, which fits perfectly inside the outer cannula, a pilot or obdurator which, when inserted in the outer cannula, makes a smooth, tapering, closed end, thus enabling one to insert the tube without causing trauma, and tracheotomy tapes. Tracheotomy tapes should be made of tape ¾ inches wide and cut about twelve inches long. Not less than one inch from one end a slit about ½ inch long should be cut. Never cut a piece of the tape out, as this weakens it and makes it unsafe for use.

The insertion of a tracheotomy tube should be made without using force. The tube to be inserted should be put through a piece of gauze which has been slit and wet with bichloride of mercury 1–10,000 solution. There should be no ravelings on the gauze, as they might be inspirated into the wound or tracheotomy tube. To insert, the tube is held firmly between the index and middle fingers and the obdurator held in place by the thumb. With the tube in this position and the back of the operator's hand held toward the wound, the tube can be inserted very easily. The tape is tied at the back of the patient's neck, in a square knot, reinforced by another knot. In tying a tracheotomy tape there are three important points to be remembered:

1. If the tape is too tight, the tube will press too firmly against the wound
2. If the tape is too loose, the tube may slip out of the trachea. Unless this condition is recognized almost immediately the patient may asphyxiate.
3. The knot must be tied securely so there will be no danger of its slipping or becoming untied.

After-care of tracheotomized patients. For the first few days, at least, special nurses for day and night duty are very necessary. No matter

how skillfully a tracheotomy has been performed, the patient's life is greatly dependent upon proper nursing care. The tracheotomy has been necessary because of lack of sufficient air entering the lungs through the larynx, therefore nothing has been gained if the tracheotomy tube is not kept free from obstruction. As soon as the patient is returned from the operating room a tray, which contains the following sterile articles, should be at his bed side:

1 Trousseau's tracheal dilator
2 Jackson's tracheotomic retractors
1 *duplicate* tracheotomy tube, complete
1 pair thumb forceps
1 curved hemostat
1 pair scissors
1 Jackson's tracheotomic aspirator with Tucker valve
1 basin alcohol 95 per cent
1 basin sterile water
1 basin bichloride of mercury, 1–10.000 sol.
1 pair gloves
2 towels
1 package dressings
Vaseline.

The metal parts of one tracheotomy tube are not interchangeable with the metal parts of another, even though they are of the same size and style, therefore each complete tube must be kept by itself.

In addition to the tray with its contents, a suction pump should be kept at the patient's bedside, also strips of gauze bandage and tonsil wire, cut in desired lengths. These are used for cleaning the tracheotomy cannulae.

Points to be remembered when nursing a tracheotomy case:

1. A patient who is not getting air through the larynx can make no sound, therefore is unable to call for help.
2. Cyanosis is a dangerously late symptom of dyspnea.
3. Secretion must be sponged off the tube as soon as it is coughed out, so it will not be drawn back with the next inspiration.
4. For the first few days, at least, the inner cannula should be changed no less often than every half-hour.
5. The cannula must be thoroughly cleansed before boiling.
6. Aspiration of secretions with the suction pump will clear the trachea below the tube. This is especially necessary when the patient does not cough, or when the secretion is very thick and tenacious.
7. The outer cannula should be changed at least once in every twenty-four hours. While this is usually done by the surgeon, the nurse must be ready for it at any moment.
8. The fresh tube must be entirely ready to insert before the tape, which is on the tube in the trachea, is cut. The trachea begins to close as soon as the tube is removed.
9. When cutting the tape of the tube which is in the trachea, it should be cut at each side of the tube, thereby preventing any change in the position of the tube.
10. Even though a patient is up and about sudden dyspnea may occur.
11. The patient's gown should be low-necked, or worn with the opening in front.

Cleaning tracheotomy tubes is a very important part of the nurse's work. When the tube is removed, it should immediately be put to soak in cool or tepid water. This will help loosen the secretion from the sides of the cannula. Pipe cleaner may be used to clean the cannulae, although the method used in the Chevalier Jackson Bronchoscopic Clinics is to cut a piece of tonsil wire about three times the length of the canrula to be cleaned, then double the wire. The loop of the wire is then passed through the distal end of the cannula, and a piece of gauze bandage about six inches long is put through the loop. This is drawn through the cannula. Sometimes the process must be repeated three or four times in order to get the tube perfectly clean. Just as soon as a tracheotomy tube is removed, it should be cleaned and resterilized so that it will be ready when needed. It may be needed in five

minutes or it may not be needed for another twenty-four hours, but it should be kept sterile at all times.

Tracheotomy, laryngostomy, and laryngofissure cases require practically the same nursing care.

Inhalations. In many tracheotomized patients the secretions have a tendency to form crusts. These crusts sometimes prove to be a very serious complication as they may form below the tracheotomy tube and obstruct either the tracheotomy tube or possibly a main bronchus. As the formation of these crusts is largely due to lack of moisture in the air, the condition can be overcome to a great extent by supplying extra moisture. This can best be done by making a croup tent over the patient's bed, then using a vaporizer to fill the tent with steam.

An Interesting Case

Epidemic Meningitis and Intussusception of the Ileum

LOUISA D. HICKMAN, R.N.

R. R., 15 years old, was admitted to the hospital at 9.30 p.m. on Saturday, April 21. Her temperature was 98°, pulse 98, of good quality, respirations 20. She had had convulsions and was unconscious on admission.

Her present illness had begun ten days earlier with nausea, followed, three days later, by projectile vomiting. For four days before admission to the hospital she had not retained food or fluids. Of some interest was the fact that for the past year she had been subject to intestinal disorder and vomiting whenever she became excited or ate too quickly.

Physical examination showed her to be in fair general condition. Most significant were her greatly dilated pupils, her slightly inflamed throat, and her dry skin. Her heart and lungs were negative and palpation of the abdomen revealed no masses nor tumors. The diagnosis of epidemic meningitis was made.

Spinal puncture was done at once, under ether anesthesia to control the child's convulsions. There was no increase in the pressure of the fluid which was clear.

Analysis of a catheterized specimen of urine showed:

Color—pale straw
Specific gravity—1024
Reaction—alkaline
Red blood cells—few (patient menstruating)
Granular casts—few
Sugar—negative
Albumen—slight trace
Occult blood
Acetone
Bile

The blood count showed:

Red blood cells—4,750,000
White blood cells—26,600
Hemoglobin—95 per cent
Polymorphonuclears—97 per cent
Small lymphocytes—7 per cent
Abnormal cells

Medical and Nursing Care

The doctor's orders included:

1. Strict isolation.
2. Morphine sulphate, gr. ⅙, by hypodermic, p. r. n., for extreme restlessness.
3. Normal saline, 1000 c.c. by hypodermoclysis, stat. (This was given for stimulation and to increase the amount of fluid in the body.)
4. Glucose and sodium bicarbonate, 5 per

cent solution, as Murphy drip. (This was given to prevent acidosis.)
5. Forced fluid diet.
6. Temperature, pulse and respiration, to be taken every two hours.

The nursing care included isolation and absolute quiet, frequent baths to help increase elimination through the skin, and particular precautions with regard to excreta and secreta.

Progress

DURING the first night in the hospital, R. R. was restless and had incontinence of urine. At 6, Sunday morning, her temperature, pulse and respiration were 98°, 88, 18. Spinal puncture was done at 10 a.m., again under ether anesthesia. 60 c.c. of fluid were withdrawn and 28 c.c. of antimeningococcus serum were given intraspinally. The spinal fluid showed many pus cells, a few Gram negative diplococci, some being intracellular. At 6 that evening there was no rigidity of neck or limbs and the patient's temperature, pulse and respiration were normal. A spinal puncture was again done at 8.30 p.m. 15 c.c. of spinal fluid were withdrawn and antimeningococcus serum was injected. 1000 c.c. of normal saline were also given intravenously. At 10 p.m. the patient's condition was slightly improved and she was rational for a short time.

Proctoclysis was continued during this time and, in addition, the patient was fed by means of a two-ounce ear syringe, the nozzle of which was inserted gently between the firmly clenched teeth and well toward the back of the throat. In this way surprisingly large quantities of nourishment were taken without apparent irritation or discomfort to the patient.

During Monday, the third day after admission, the patient's condition remained satisfactory, her pulse was of good quality, she rested quietly but was still irrational and incontinent. Spinal puncture was done once, 60 c.c. of cloudy fluid were withdrawn under great pressure and 50 c.c. of antimeningococcus serum were injected. Examination of the fluid showed many pus cells and extracellular diplococci. Toward evening the patient's general condition showed marked improvement. She was rational and there was no rigidity of neck or limbs. Fluids were tolerated so well by mouth that proctoclysis was discontinued.

However, she did not rest well after midnight and on Tuesday morning, the fourth day after admission, her condition was markedly worse. Her finger tips were cyanosed; there was great rigidity of the neck and limbs with retraction of the head; she had much difficulty in swallowing; her pulse, though of good quality, had increased to 120, while her temperature was 97°. Although only semi-conscious, she still responded intelligently when spoken to.

Through the day her condition did not improve, the restlessness continued and she had fecal as well as urinary incontinence. She was unable to expel a soapsuds enema and it was siphoned back. Spinal puncture was done during the morning, 60 c.c. of cloudy fluid were withdrawn under great pressure and replaced by 45 c.c. of antimeningococcus serum. The spinal fluid showed a cell count of 1760, uncentrifuged, with rare organisms. During the evening 50 c.c. of antimeningococcus serum in 20 c.c. of glucose solution were given intravenously. This treatment was followed by a severe reaction with Cheyne-Stokes respiration and weak irregular pulse of 120. Caffeine and sodium benzoate, gr. 7½, were given by hypodermic and toward midnight

the patient's condition seemed improved. During the night 5 per cent glucose and sodium bicarbonate solution was given by proctoclysis.

On Wednesday the improvement continued. R. R. was able to take eggnogs, the rigidity of the neck and limbs had decreased, her temperature, pulse and respiration were normal. One spinal puncture, the last, was done, 40 c.c. of fluid were removed and 50 c.c. of antimeningococcus serum injected. Examination showed the spinal fluid to be still cloudy, though the cell count had fallen to 170; a smear showed many polymorphonuclear cells, red blood cells and one group of organisms.

For the next three days R. R.'s condition improved greatly. She was rational and took nourishment well by mouth. Her only difficulty was in expelling the enemas which were given and twice these had to be siphoned back. However, on Saturday an enema was given with excellent results and a large formed stool was expelled normally.

On Sunday, the ninth day after admission, the patient appeared in good condition. She was given citrate of magnesia, 8 oz., by mouth at 10 a.m. Fifteen minutes later she vomited all the fluid projectilely. At 10.30 a soapsuds enema was given with very good results and at 4.30 she vomited projectilely 1000 c.c. of material resembling feces but without odor. She did not complain of abdominal pain during the day; her temperature, pulse and respiration were 98.4, 98, 18, and she took feedings well.

On the next day, Monday, she seemed weaker. An enema was given and returned as clear fluid with particles of fecal matter. From 8 a.m. all food by mouth was stopped and citrocarbonate, 1 teaspoonful in 8 oz. of water, was given every four hours. At 12.30 p.m. she complained of abdominal cramps which were relieved almost at once by the application of a deep therapy lamp over the region. Her temperature, pulse and respiration at 6 p.m. were 98.4, 100, 18.

About 8 a.m. on the morning of the 11th day after admission, Tuesday, after a good night without vomiting, the patient passed a constipated stool. At 3.30 p.m. she complained of abdominal discomfort and a soapsuds enema was given, which returned with a large constipated stool. Half an hour later, 3 oz. of warm olive oil were injected into the bowel. At 5 p.m. she vomited projectilely 2000 c.c. of fluid of the same character as that vomited on Sunday. Following the attack the patient was much exhausted and complained at intervals of cramping abdominal pains. At 8 p.m. a milk and molasses enema was given with very good results.

Twice during Tuesday night R. R. vomited projectilely and continued to do so at frequent intervals during Wednesday. Glucose and sodium bicarbonate solution, 5 per cent, was started by proctoclysis but was not retained. Calophen tablets ii (gr. ss. in each tab.) were given at 10.30 and repeated in half an hour. Ice packs to the throat were given to relieve any irritation due to vomiting. At 6 p.m. the temperature, pulse, respiration were 97°, 120, 24.

During the evening an abdominal examination was made by Dr. —— and a "high" milk and molasses enema ordered, which returned with excellent results. At 9 a barium meal was given and repeated in two hours. The patient had a fair night without vomiting.

X-ray examination next day, Thursday, revealed a partial obstruction of the small bowel, evidently in the region of the first part of the jejunum.

A consultation was held and surgical intervention decided upon. Preparations for operation were made at once and a pre-anesthetic hypodermic of morphine sulphate gr. ⅛ and atropine sulphate gr. 1/150 given.

On operation, a diverticulum of the intestine, with intussusception of the ileum, was found. The intussusception was reduced, a portion of the bowel with a mesenteric cyst two and a half inches in diameter was removed, and a lateral anastomosis done.

Postoperative treatment included 1000 c.c. of normal saline intravenously immediately after operation and proctoclysis of 5 per cent glucose and sodium bicarbonate solution (with adrenalin 1 drachm in the first pint) for 48 hours. Nothing was given by mouth for twelve hours, then sips of hot water were given hourly during the second twelve hours and on the third day, clear broth. On the third and fourth days after operation soapsuds enemas were given with excellent results and on the fifth day, castor oil 1½ oz. was given, followed by large, soft, formed, normal stools. After this, the patient was given a soft diet for 48 hours and, gradually, general diet. There were no complications and on the 10th day after operation she was taken home. She has made rapid and very satisfactory progress. Members of the hospital staff have visited her since her return and report that she is "doing well and looking fine."

As I had the privilege of nursing this interesting case I realized what it means to a seriously sick person to have the advantages of being in a modern hospital with all its equipment ready to aid in extreme conditions with clinical, pathological, x-ray, and diet laboratories. Nurses of today certainly have the advantage of what the American Medical Association and the American College of Surgeons have done and are doing in standardizing hospitals throughout the country.

American Child Health Association's Statistical Report of Infant Mortality for 1928

SOME of the outstanding points are:

1. The infant death rate is 69.3 for the 719 cities of the Birth Registration Area.

2. Last year's rate was 64.9 for 683 cities then in the area.

3. The 1928 rate is, next to the 1927 rate, the lowest ever achieved.

4. The baby death rate today is two-thirds what it was 15 years ago.

5. "The United States is fast approaching the time when it may know its own birth and death rates." When a rate was quoted for the United States in 1925 it reflected only the figures from 10 states and the District of Columbia which then constituted the Birth Registration Area. In 1928, 44 states and the District are included. One more state was added in 1929, leaving but three states now with unacceptable records.

6. For the population group over 250,000, the cities with the lowest rates were Seattle, Washington, and Portland, Oregon, 43; San Francisco, 46.

* * * * *

12. "Presence or absence of institutions, state of wealth, family customs characteristic of different race and nationality groups, knowledge and probably climate, each have an unquestioned part in determining the size of the infant mortality rate and these influences must be reckoned with, as well as the thoroughness of the prenatal and infant welfare programs."

13. "As a meter of public health progress, contributed to from various channels, the infant mortality rate is most serviceable as an index of trend from year to year within the same city."

14. Among 10 large cities of the country, New York has improved its relative standing from 3rd in 1916–1920, to first in 1925–28. Philadelphia has advanced from 7th place to 5th place, Cleveland from 4th to 2nd. Boston has retired from 5th to 9th place, St. Louis from 2nd to 4th and Los Angeles from 1st to 3rd. — S. J. CRUMBINE, General Executive.

A Study of Breast Care

Part II—Methods of Breast Care During the Puerperium

M. CORDELIA COWAN, R.N.

IN 1925, at the Woman's Hospital (New York) rather complicated nursing procedures were being used in breast care. To see if this technic might be simplified and improved, a short experiment was made. Two methods were run parallel, alternating the new and the old as the patients were received into the ward. In the study of this short series, only 200 cases, not quite as many developed mastitis under the new simplified care as under the old technic. While the findings from so few cases could not be taken as definite evidence of improvement in the prevention of infection, the simplified procedures did seem to warrant a fair trial because they gave much greater comfort to the patient and saved time and materials. Consequently, it was decided to give the simplified method further trial.

Old Method

PREPARATION OF THE BREASTS BEFORE THE FIRST NURSING

Tray
Treatment square
Rubber sheet
Paper bag
Breast straps
Alcohol, 65 per cent
Green soap
Sterile:
- Forceps in lysol, 3 per cent
- Boric solution 2 per cent
- Vaseline
- Toothpick applicators
- Nipple gauze
- Cotton balls, 2 bags
- 2 towels (in package)
- Package (in towel)
  - 2 solution basins
  - Kidney basin

Preparation of the tray

Unwrap the basins and fill one solution basin with sterile water and the other one with equal parts of sterile water and green soap.

Make sure sufficient supplies are in containers.

Open each bag of cotton balls and turn back a deep cuff without touching the inside.

With the forceps, place 2 cotton balls in the kidney basin and 4 each in the solution basins of sterile water and green soap solution.

Procedure

Take the tray to the bedside.

Slip the rubber sheet covered with the treatment square beneath the patient to protect the bed.

Open the package of sterile towels.

With the forceps, pick up a sterile towel by one corner and then, handling it only by the corners, place it over and fold it under the patient's gown which has been folded back up to expose both breasts.

In the same way place the other sterile towel over and tuck it under the folded-back bedclothes.

As each breast is scrubbed, support it from below with the left hand.

Using the forceps, pick up a sterile cotton ball from the soap solution, press it against the side of the basin to rid it of excess soap solution and, beginning at the nipple, use a circular route to cleanse the entire breast.

After cleansing the farther breast in this fashion, take another cotton ball and cleanse the nearer one.

Repeat the process with fresh cotton balls, using in all for the soap solution, 4 cotton balls or more as is necessary.

Rinse the breasts with sterile water in the same way that the soap solution was used, beginning with the farther breast, alternating, and using in all, for the sterile water, 4 cotton balls or more if necessary.

After rinsing, sponge each breast with alcohol, pouring the alcohol over the cotton balls in the kidney basin and using a cotton ball for each breast.

Wash the nipples with sterile applicators wet with boric acid solution.

Anoint the nipples with sterile vaseline.

Place sterile gauze over the nipples and apply the breast straps.

Adjust the gown and bedclothing and make the patient comfortable.

Remove the tray from the room.

Re-sterilize the basins and rewrap them in a

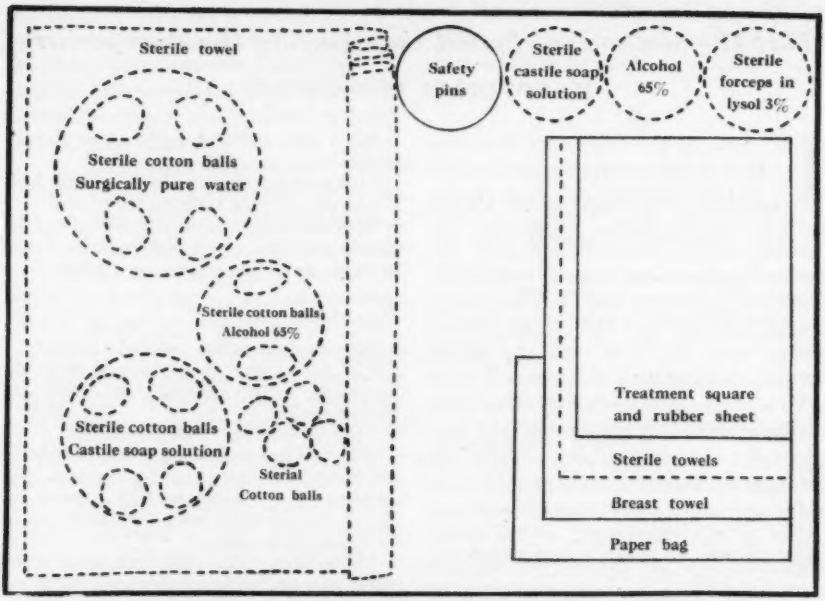


FIG. 1. TRAY FOR FIRST PREPARATION OF BREASTS (SET UP FOR USE)

sterile towel, replenish supplies, and put the tray in order ready for use.

CARE OF BREASTS BEFORE AND AFTER NURSING

Articles

Tray
Kidney basin
Sterile:
- Vaseline
- Boric acid solution, 2 per cent
- Toothpick applicators
- Nipple gauze

Procedure before nursing

Untie the breast straps and remove the nipple gauze.

Cleanse the nipples with sterile applicators wet in the boric acid solution.

Procedure after nursing

Anoint the nipples with sterile vaseline after washing them with the boric solution.

Cover the nipples with sterile gauze and retie the breast straps.

Report any abnormality as old scar, abnormally shaped nipples, sore nipples, etc., to the nurse in charge.

New Method[1]

PREPARATION OF THE BREASTS BEFORE THE FIRST NURSING

Articles (Figure 1)

Tray
Treatment square
Rubber sheet
Paper bag
Breast towel
Safety pins
Alcohol, 65 per cent
Sterile:
- Forceps in lysol, 3 per cent
- Castile soap solution
- Cotton balls, 2 bags
- 2 towels, (1 package)
- Package (in towel)
- 3 solution basins

Preparation of the tray

Place the package in the sterile towel with the folded outer end toward the center of the tray.

Open the package on the left hand side of the tray and fan-fold the folded end of the towel to the center of the tray.

[1] Cowan, M. Cordelia, "Woman's Hospital Manual of Nursing," p. 47.

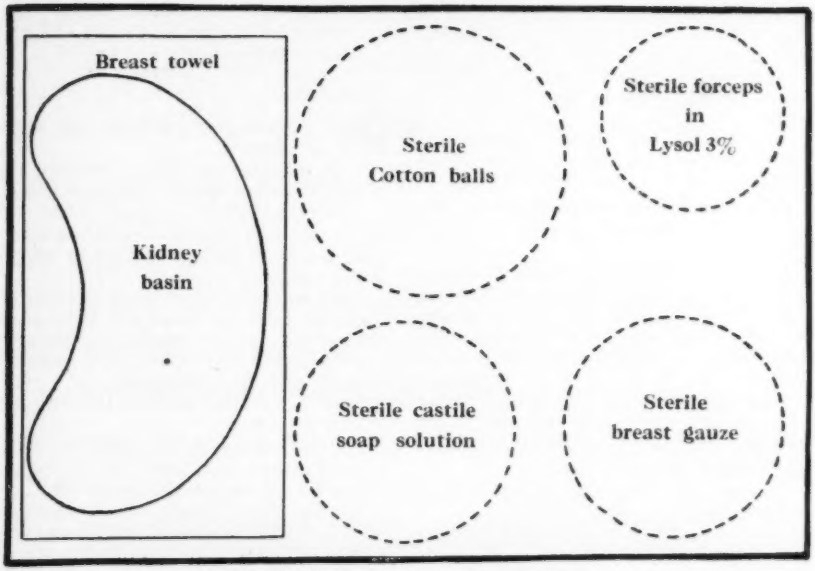


FIG. 2. TRAY FOR DAILY BREAST CARE

Arrange the sterile basins on the tray in the following manner:

Place large basin for the surgically pure water to the farther left hand corner, medium basin for the castile soap solution to the nearer left hand corner, and the small one to the right of the others.

Half fill the large sterile basin with surgically pure water (water that does not contain pathogenic bacteria, the ordinary tap water and preferably taken from the hot water tap) and the medium one with castile soap solution.

Open the bags of cotton balls and turn back a deep cuff on each as they are emptied.

With the forceps place 2 cotton balls in the smallest basin, 4 each in the solution basins of surgically pure water and castile soap solution, and the remainder on the sterile surface of the towel. (Figure 1.)

Over the 2 cotton balls in the smallest basin pour just enough alcohol, 65 per cent, to moisten them.

Cover the basins with the folded-back end of the towel.

Procedure

Take the tray to the bedside stand at the left of the patient.

Have the patient place her arms above her head, fold back the covers and the gown to entirely expose both breasts, and hold the gown in place by tucking the folded side edges under the ends of the pillow.

Slip the rubber sheet covered with a treatment square beneath the patient to protect the bed.

Arrange a paper bag to catch the soiled cotton balls by tucking one side of the open end in between mattress and springs and folding in five or six inches of the other three sides to hold the bag open.

Partly open the package of sterile towels, leaving one corner over the sterile towels until the hands are scrubbed.

After scrubbing the hands and returning to the bedside, complete the opening of the package of sterile towels.

Handling the towel only by the corners, pick it up, fold it once from side to side, place it over the patient's folded-up gown with the fold toward the patient's chin, and tuck it under at its lower edge.

In the same way fold the other sterile towel, place it over the folded-back bedclothes, and tuck it under at its upper edge.

Uncover the basins by fan-folding the towel back to the center of the tray.

As each breast is cleansed, support it by grasping the adjacent soft tissues from below with the left hand.

Using the forceps, pick up a cotton ball from the soap solution, press it against the side of the basin to rid it of excess soap solution and, beginning at the nipple, use a circular route to cleanse the entire breast.

After cleansing the farther breast in this fashion take another cotton ball and cleanse the nearer one.

Repeat the process with fresh cotton balls, using in all 4 cotton balls or more as is necessary.

Rinse the breasts with surgically pure water in the same way that the soap solution was used, beginning with the farther breast, alternating, and using in all for the surgically pure water 4 cotton balls or more as needed.

After rinsing, lightly sponge each breast, this one time only, with one cotton ball slightly moistened with alcohol to facilitate the drying of the skin.

Use the inner clean surface of the upper towel to dry the breasts.

As the procedure is carried out, inspect the breasts most carefully for old scars and any other abnormalities.

Using the lower towel and turning it to bring the inner clean surface next to the patient's skin, refold it from end to end to cover the breasts and hold it in place by pinning it to the gown with 2 safety pins, one on each side, well above the upper margins of the breasts.

If the lower towel becomes soiled or wet during the procedure use the breast towel instead and fold it so that the inner surface will come next to the patient's skin.

Remove the paper bag, rubber sheet, and treatment square.

Adjust the gown and bedclothing, make the patient comfortable, and remove the tray of soiled articles from the room.

Re-sterilize the basins and rewrap them in a sterile towel, replenish supplies, and put the tray in order for future use.

Record the treatment given the breasts and a description of any abnormal condition discovered at that time.

DAILY CARE OF THE BREASTS

Articles: (Figure 2.)

Tray
Kidney basin
Breast towel
Sterile:
  Forceps in lysol, 3 per cent
  Weak castile soap solution in jar
  Cotton balls in jar
  Breast gauze in jar

Procedure

Carry out the procedure once daily, before the 10 a.m. feeding.

When ready to carry the tray to the bedside of the patient remove the lids from the sterile containers and half fill the soap container with very weak, surgically pure, castile soap solution, about the strength needed to wash a child's face.

Have the patient place her arms above her head, fold back the covers and gown to entirely expose both breasts, and hold the gown in place by tucking the folded side edges under the ends of the pillow.

Unpin the soiled breast towel and use it to protect the bed.

Beginning at the nipple and using a circular route to cleanse each breast, wash the breasts with the very weak castile soap solution.

Starting with the farther breast, supporting it by grasping the adjacent soft tissues from below with the left hand, and using the forceps to handle the cotton balls, alternate the cleansing of the breasts and use at least 2 cotton balls moistened, but not saturated, for each breast.

After cleansing with the very weak castile soap solution, dry each breast with a small piece of sterile gauze.

As the breasts are cleansed, inspect them carefully for any abnormalities.

Cover the breasts with the inner surface of the clean breast towel that is folded once, from end to end, and hold it in place with the 2 safety pins.

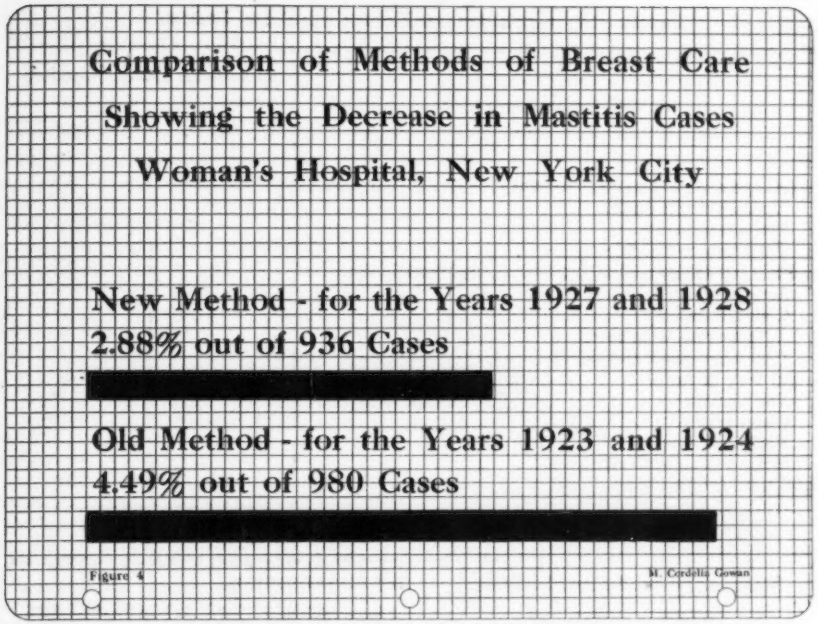
Remove the soiled towel from beneath the patient, adjust the gown and bedclothing, make the patient comfortable, and remove the tray from the room.

Re-sterilize all containers and lids, replenish the supplies, and set up the tray ready for future use.

Record the treatment given the breasts and the condition of the breasts at that time.

Comparative Study of the Two Methods

The use of the simplified procedures with the four-hour feeding schedule, for the past three years, now provides a long series of cases that can be compared with a long series that were cared for previously and for which



COMPARISON OF METHODS OF BREAST CARE

more complicated procedures and the three-hour feeding schedule were used.

A period of two years has been selected for the study of each method, taking the years 1923 and 1924 for the study of the old method and the years 1927 and 1928 for the study of the new one. Out of the total of 980 nursing mothers who were treated under the old method, 44 of them or 4.49 per cent developed mastitis, while out of 936 nursing mothers who were given care under the new method, only 27 of them or 2.88 per cent developed mastitis during the patients' stay in the hospital.

Other factors in nursing care and medical treatment remained practically the same so that the conclusion seems to be justified that the reduction in per cent of mastitis cases is due to the improvement in method.

Simple time studies have been done to show the saving of time through the use of the new method. This saving of time brought about by the adoption of the four-hour feeding schedule and the simplified procedures is most readily seen in the tables on the following pages.

These tables show a saving of 10 minutes on each first preparation of the breasts, a saving of 30 minutes a day in the daily care of the breasts on the basis of one patient, and a saving of 252 minutes on the basis of 20 patients, or about 13 minutes saving in the daily breast care of each ward patient.

Besides the saving of time spent to carry out the actual procedures, fewer materials are required for the new method and a saving is affected thereby in both the materials and the time given to prepare them.

PREPARATION OF THE BREASTS BEFORE THE FIRST NURSING

One Patient Only	Minutes for Doing Procedure	
	Old	New
To arrange and prepare tray for use	3	3
Arrange sterile basins		
Prepare solutions		
Take tray to bedside		
To carry out technic	17	9
Arrange gown and bedclothes		
Cleanse breasts		
Adjust dressing or towel		
Rearrange gown and bedclothes		
To put tray in order	16	14
Boil basins		
Clean tray		
Replenish supplies		
Wrap basins in sterile towel		
Total time for procedure	36	26

Summary and Conclusions

1. The breasts of the newborn are better left strictly alone and under no consideration should they be squeezed or handled unnecessarily.

2. At the time of adolescence a supportive type of brassiere should be used if the breasts are so large that they tend to sag and clothing should be selected that will not flatten nor pull the breasts downward.

3. During pregnancy, measures should be used to keep the skin of the nipples in good condition and to give support to the developing breasts.

4. The care given during the puerperium should lessen the dangers of infection at that time and should establish habits and routines to be followed throughout the lactation period.

a. The mother should be taught how to avoid the dangers of infection so she can cooperate in its prevention.

b. The skin of the nipples may be kept intact, smooth, and soft through the use of non-irritant agents for cleansing, the retention over the nipple of the film of milk that is high in fat, and the prevention of unnecessary friction.

c. The normal circulation may be facilitated and the greatest possible comfort may be afforded the patient by support of the breasts from the breast binder when needed, dispensing with it otherwise, especially through the hot days of summer.

d. The establishment of a good milk supply may be obtained by good hygienic measures for the mother and by the regular stimulation of her breasts.

e. The three- to five-minute nursing period, every four to six hours, before the establishment of the milk supply gives ample stimulation to the breasts without undue irritation and allows the infant to receive the maximum benefits to be derived from the colostrum.

f. After the milk supply is established, the infant can be properly nourished on a four-hour nursing schedule with a maximum nursing period of twenty minutes.

g. The omission of the night feeding (2 a.m.) gives the mother a better chance for a good night's rest and helps the infant to form the desired habit of sleeping through the night.

5. In the comparative study of the two methods the simplified procedures with the four-hour nursing schedule appeared to have the following advantages:

a. In the long run just as good gains were made by the infants on the four-hour schedule as by those on the three-hour schedule and the mothers and babies were more comfortable.

b. Fewer cases of mastitis developed under the new method.

c. The procedures of the new method require less time and fewer materials.

DAILY CARE

One Patient Only	Minutes for Doing Procedure	
	Old	New
To obtain and prepare tray for use	(2)	2
Supply any needed materials	7 × daily	1 × daily
Take tray to bedside	14	
To carry out technic	(3)	3
Arrange gown and bedclothes	7 × daily	1 × daily
Cleanse breasts	21	
Adjust dressing or towel		
Rearrange gown and bedclothes		
To put tray in order	14	14
Boil basins	1 × daily	1 × daily
Clean tray		
Replenish supplies		
Total time for procedure	49	19

Twenty Patients	Minutes for Doing Procedure	
	Old	New
To obtain and prepare tray for use	(2)	2
Supply any needed materials	7 × daily	1 × daily
Take tray to bedside	14	
To carry out technics	(40)	40
Arrange gown and bedclothes	7 × daily	1 × daily
Cleanse breasts	280	
Adjust dressing or towel		
Rearrange gown and bedclothes		
To put tray in order	14	14
Boil basins	1 × daily	1 × daily
Clean tray		
Replenish supplies		
Total time for procedure	308	56

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An Unusual Badge

AN INTERESTING BADGE

THE General Infirmary at Leeds, England, of which Miss E. S. Innes is Lady Superintendent (Superintendent of Nurses), has, in coöperation with the University of Leeds, a five-year course. To distinguish the nurses who have passed the University examinations for the Diploma in Nursing (five-year course) from those who have only the qualifying certificate of the Hospital Course, the Gryphon, symbol of the University, has been added to the well known badge of the Hospital School.

The relation of the School of Nursing to the Medical School of the University is a happy one. Some years ago the Medical Students' Representative Council requested that representatives of the Nursing School meet with them to discuss school colors. Since then nurses in their fourth year of training, after they qualify for the University, are permitted to wear the School of Medicine blazer, tie and scarf. Yet another outward evidence of the fundamental relation of the two schools is shown in the little safety pins for pinning the apron bibs, carrying the colors which may be used by all the nurses accepted for the completion of training after the preliminary examinations are successfully passed.

Schools in the Shriners' Hospitals for Crippled Children

FLORENCE J. POTTS, R.N.

IT is obvious that means for the physical rehabilitation and general education of the crippled child of school age should be arranged simultaneously and in a way that will be of the greatest advantage to him. We all appreciate that the child who has been deprived of an education and has, in addition, a physical handicap is a greater liability to the community than the physically normal child with the same educational disadvantages. This fact has been recognized by the trustees of the Shriners' Hospitals for Crippled Children, as will be seen by the following outline of the work. Excellent progress from this standpoint has been made during the comparatively short period these hospitals have been in existence.

School teachers are provided by the Boards of Education in the various localities where these special hospitals are located. The schools are under direct supervision of the Department of Special Education and are frequently visited by supervisors in music, drawing, academic and industrial art. The supervisors are usually women of wide experience as teachers and executives, and their knowledge of child psychology is broad. In one of the larger units, the school is provided with two academic teachers, one industrial art teacher, and one academic teacher to instruct the children who are confined to bed.

The courses of study pursued in these hospitals are those prescribed in the public school curriculum and these are modified and adapted to the individual needs and ability of the pupils. Obviously there must of necessity be variations in the details carried on in the schoolrooms in the various localities, but fundamentally the system is uniform in all the Shriners' Hospitals for Crippled Children. The teaching situation demands adaptation and coöperation. Adaptation and coöperation must come first, as these institutions are primarily hospitals, not schools.

It has been found that the average crippled child is by no means less intelligent nor less able to absorb knowledge than the normal child. There are many outstanding cases where he has done far better work than a normal child of the same age. As a whole, the physical condition of the crippled child seems to have little to do with his mental ability. In the city schools, the use of mental tests has accomplished much toward properly grading the pupils. But some of our teachers say it is obviously unfair to attempt to grade the children in these hospitals according to mental tests, because in most instances long absence from school explains the variance between their chronological and mental ages.

In the hospital groups, retardation is usually the result of physical handicap—though sometimes it can be traced to the social group to which the parents belong. For instance, the parent may be of the moron or even the degenerate type; or, in contrast to the professional and superior economic classes, the parent may belong to the unskilled-labor class—and again the parent may speak only a foreign tongue.

No matter to what mental group the child belongs, he is usually eager for enlightenment or improvement

along one line or another. The problem is to find this interest. To illustrate, let me tell a little about Armand. When Armand first became an "up-patient" the teacher "worked him" into a history group already in progress. He was sure he would like history—though she knew the work of the group to be beyond his previous preparation. She found that he "listened-in" well but was so contented with just "listening-in" that he was making no individual effort. The history group came to an end and the teacher had more time to attend to Armand's needs. One subject after another was tried in an attempt to arouse his interest. But since the boy was now without classmates, there was no inspiration for him, and his lessons failed to capture his interest. Happily these unattractive lessons could be abandoned, as the teacher had found just the thing to awaken his pride and interest, namely, an arithmetic manual in which the lessons were a step harder each day. On the back cover of the book is a graphic chart for recording the pupil's "ups" and "downs" in arithmetic. Spontaneity and accomplishment were the result of each arithmetic lesson.

Competition plays an important part in the teaching of arithmetic as it stimulates interest. Objective teaching is essential to imbibe the fundamentals. The lesson must be made realistic and this is done by assigning practical arithmetical problems. A child may be able to tell what five times six are but the following will present difficulties to him if he has not had practice. For example: If I pay five cents for one pencil, how much do I pay for six pencils?

After surgery has corrected their deformities, the child may become a part of the commercial life of the community. Because of this, the teachers aim to give particular attention to the study of arithmetic and its problems by means of projects and other aids and devices. As an example, the children construct of pasteboard a three-ring circus project. From this they develop original problems in arithmetic. These include inventories, insurance, risks in business enterprises, commission, discounts, interest and banking. This achievement in handwork was extended and applied to language, history, geography, spelling, hygiene, civics and reading.

Many children of the fifth, sixth and seventh grades who have not attended school for a long period, have very little knowledge of the rules and syntax of grammar. It is, therefore, necessary to explain the rules when the occasion arises, for example, in the sentence: "Is this a blue book?" the teacher asks the following questions: "Why put a capital letter for 'is'? Why use the interrogation point? Change the interrogative form to the declarative form of sentence."

As spelling is such an important element in all written expression, the teachers give much drill along that line. While not all of the children are good spellers, they are very fond of written spelling tests and even the old-fashioned spelling-match is quite popular in the hospitals. Especially is rivalry keen when a prize is offered the winner. The children often ask: "May we have a spelling-match?"

The industrial arts class is one branch of the work that makes a big appeal to the boys and girls. Rooms are fitted up as modern shops with tables, work benches and a closet of tools that would make any boy's heart leap for joy. Here all are given an opportunity to make things for

SCHOOL IS CONTINUED DURING THE SUMMER MONTHS

mother or perhaps to make a little toy for some favorite baby in the ward. The purpose of this course is twofold, the vocational and the general educational. The latter is stressed with these children. Oftentimes an incentive is supplied which allows a child to become a very efficient worker along one of the lines taught in our shop and to choose that line of work for his vocation. Woodwork, pottery, textiles, paper and book-making, and basketry are some of the things taught. The subject is most effective according to the degree in which it helps the child to become more efficient in the selection, care, and use of the different products of industry.

The children are encouraged to give free expression to opinions and ideas, thus developing an open forum. During these recitation periods the teacher, as instructor and adviser, emphasizes correct speech. Excellent response is seen in the ward classes. Here are assembled children from a wider section of our country than the average schoolrooms hold. Geography is a subject for keen discussion. This boy comes from West Texas with its cattle ranches and oil fields, another comes from Oklahoma's wheat district, another from Arkansas' orchard counties. There are others who can tell of the iron mines, the cotton and rice fields, and of cities where foreign ships bring interesting cargoes. Recently a study of rivers was made exciting by considering the rivers crossed by each child on his or her journey to the hospital. Bridges,

ferries, and good roads come in for their share of study.

This same variation of subject matter is noticeable in the study of nature and animal life. Expression, proper forms of grammar, and colloquialisms are all met and dealt with in these classes.

Some very interesting cases have been those which dealt with the progress made in English by the French-speaking children. The method used in teaching them is as follows: All work is taken orally for a certain period. At first the child is asked to point to the different objects near at hand and is taught the expressions most commonly used. He is then able to answer questions as, "What is this? Where is the box? What is your name? *Qu'avez-vous à la main? Combien de crayons avez-vous?*" (What have you in your hand? How many crayons have you?) The teaching of the names of the days of the week and the months of the year constitutes the early lesson plans. The pupil is now ready for written work. The teacher writes and reads the different words and the pupil translates them: "Teacher: The bed. Pupil: Le lit." The pupil is later able to read and write these himself. Direct imitation is the best advice to use for correction. Few words are dealt with during a lesson, so as to avoid confusion. Exercises of great value are those which compel the child to use the newly-acquired word in sentences and translated exercises.

The teacher gives instruction in the writing of letters and addressing of envelopes and test exercises are handed in for correction from time to time. All pupils are also encouraged to write their own letters to their friends. A dictionary, which may be referred to at any time, is always on hand and the difficult words are used in sentences to show that the child understands the meanings.

The phonic method is used for beginners and the chief objects of this method are word-recognition and distinct enunciation. The foundation principle of success in phonics is instant word-recognition.

A problem always present is the ever-changing number of patients. The average stay in the hospital varies, but is about seventy-seven days. However, some patients are discharged at the end of five weeks while others are retained eleven or twelve months. Of this constantly changing group some are "bed patients" for most of their stay—others are "up-patients." Furthermore, a patient may have more than one operation, sometimes two or three, within a short period of time. For these and other reasons of hospital routine, the groups are constantly interrupted and broken up. Regularity and number of classes largely depend upon the number of "up-patients" and the age variation. In accord with these conditions, the needs of the children, and their interests, the method of procedure must be determined.

The teacher's first aim is to get in touch in some way with each child every day to gain his confidence at the start, and to provide some form of interesting and instructive occupation, either hand work or work of an academic nature, to suit his needs. His mind must be kept from any thought of self-pity due to his handicapped condition. Here is a story that will illustrate the attitude of mind sometimes found in these children. John, a poliomyelitis victim, had not walked for seven years. Having previously attended the Sunshine School for Crippled Children, the little fellow is now able to advance to the high seventh grade in the Shriners' Hospital

ANOTHER SCHOOLROOM

School. One day during the civics period a group was discussing the recent presidential candidates and the method of electing a president. All the members of the group were deeply interested in Mr. Hoover's possibilities. Their teacher commented on the fact of his being self-made and his having to work after school hours to help pay for his education. Much to his teacher's surprise, John asked: "Can a cripple become president?" Just this little question gave the teacher an excellent opportunity to endeavor to efface the boy's feeling of inferiority.

The type of work in the classroom groups does not differ from that in the average school. Whenever possible, correlation between subjects has been employed. This is valuable and saves time. When a group is undisturbed for a period of weeks, it has been possible to make marked progress in arithmetic, history, geography, spelling and language. Interest in nature study has been encouraged and specimens have been brought into the room for observation and study. Nature topics of common interest have formed a part of group discussions. In a few instances, the teacher has added small groups in civics and first-year high school history. As many of the children have attended school only irregularly, and some not at all, work that develops self-expression seems best suited to their needs.

One project of this type was an operetta, "The Royal Playmate," which was presented on the hospital lawn. In the operetta, a lonesome

little princess seeks a playmate, and through her kindness to an old gypsy witch, her wish is granted. The children of the cast actually were the fairylike characters in the playette, and despite their handicaps took their parts with marked spontaneity and lack of self-consciousness. For eight weeks the operetta was rehearsed; oftentimes under difficulties. For instance, three girls who formed a part of the chorus were daily brought to the schoolroom in their beds. Never once did the participants tire of rehearsals. This happy problem brought about many worthwhile results. It was quite evident that these children had developed self-confidence, poise and creative expression. Moreover, it was a coöperative problem, for the Junior Achievement workers planned staging and costumes, and all in any way connected with the hospital were ready to lend a hand. Best of all, however, the operetta lived on. Several weeks after the final performance some visitors wished to hear a few selections from the operetta. Although many of the characters were no longer in the hospital the enthusiasm of the surviving cast was beyond belief. The entire score was presented and, despite the impromptu manner, the children re-lived their parts in song and gesture.

Other projects that have been enjoyed help to cultivate aesthetic taste and discrimination. Among these are trips to the Museum of Natural History. There the children spend a most delightful hour as guests of the director who remarked that never before had she seen the museum put to finer service.

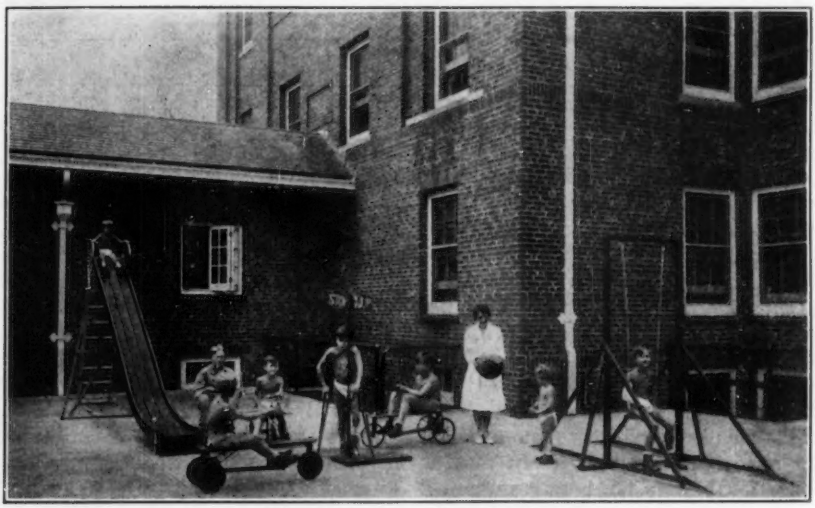
CLASSES ARE HELD IN THE OPEN AIR WHENEVER POSSIBLE

One of the teacher's most important every-day duties is the proper placing of reading material. On her initial visit to a "newcomer" the teacher's first inquiry is likely to be: "What kind of books do you like to read?" Now and then she gets the reply: "Oh, don't bother about me, I don't like to read anyway." With children so disposed, the teacher has given instant time and attention to present an especially interesting book,

usually, "Jean Valjean," an adaptation from Victor Hugo's "Les Misérables." This book is always eagerly read and greatly enjoyed. The next time the teacher visits these children she is gratified to hear such remarks as "I like books like that," "That is a dandy book, any more like it?" and "Next time bring me two books." In most instances, this newly found interest in books continues.

in and anxious to hear about Commander Richard E. Byrd's Antarctic explorations. When teaching historical, geographic and industrial subjects in the upper grades, the use of a motion-picture machine adds greatly to the interest of these studies.

An experiment is being tried in one of the units, the results of which are being awaited with rather keen interest. A playground instructor has



ONE VIEW OF A PLAYGROUND

Apart from the regular school work the teachers try to interest the patients in current events. Last year one group studied in Mexico, Central America and the West Indies with Lindbergh's tour. This included early discoveries, Spanish American war and Roosevelt's connection with Panama. They also followed President-elect Hoover on his recent trip to South America, and a most interesting book from newspaper clippings has been made and the children are specially well informed regarding the various places where the vessel stopped on the way. Many are now interested

been added to the staff and although her association with this particular unit has been of rather short duration, her special work appears to be making a very strong appeal to the children. The young woman in charge of this work is a university graduate specializing in subjects dealing with the child and his problems. A knowledge of organization, fondness for children, a personality that will appeal to children, and one who excels to some extent in athletics are essential qualifications.

Athletic ability is not so necessary in hospital work, so far as the children

TEACHING BEADWORK TO THE YOUNGER PATIENTS

are concerned, because of their deformities which do not allow for much activity, and they receive their required exercises in the physiotherapy department. The young woman of athletic type seems to make a special appeal so that this may be considered one of the qualifications for the playground instructor. The most active games are bean bag, rubber ringer, rope ringer and ball. These are played with two teams, having a captain for each team and a score marker. The inactive games consist of story telling, guessing games, craft work, singing, stories dramatized by the children, also talks on neatness, and on good sportsmanship in work and play.

The playground is supplied with the usual equipment and is used when the children receive their shoes and are able to walk. Frequently they are taken to the lawns and gardens where they sit on the grass under some of the very prettiest trees and have story hour and games. This thrills them for days and is often used as a reward for the winners of the various contests. The patients who are limited in their activities and cannot take these little trips to the lawns and gardens, look forward to it as a thing to do when they are better. Instruction in good sportsmanship is very necessary to these little hospital patients. Many of the children are learning this art, but there are still a few who cannot congratulate the winner and smilingly take defeat.

Occupational therapy has an important place in the teaching system. A great many prizes have been taken at state fairs by articles of embroidery, fully equipped doll beds, carefully dressed dolls, and bird houses, which were exhibited. To show the reaction, one little girl was given second prize for a baby doll which she had dressed. The judge had made a notation that first prize would have been granted had not a pin been used to fasten the dress. After reading the note, the child thoughtfully remarked: "Now, I knew babies should not have pins in their clothing and it serves me right. I'll never forget again."

There is no field of beneficent activity on behalf of the sick and crippled child today which offers greater opportunities for concerted effort than this field of curative work. The field is one of ever increasing opportunity

and much good can be accomplished in broadening and furthering occupational therapy through medical authorities interested in the restoration to usefulness and therefore happiness of the crippled child.

The majority of units have organized the Boy Scout movement which is a wonderful foundation for teaching civics and good citizenship. The "Do a good turn every day" slogan has proved a good reminder of a boy's civic duty. The Honor System which is embodied in the Scout rules, the games of competition, the tests of observation, have been a marvelous stimulus to the minds of these children, leading to accuracy of statement and truth, and so the Shriners' Hospitals for Crippled Children try to send these children—the citizens of tomorrow—back to their homes not only with body restored but with mind enriched.

The Retirement Income of One Hundred Nurses

A STUDY of a typical 100 income annuities held by registered nurses enrolled in the "Harmon Plan" indicates that representative nurses have found this method a desirable way of arranging during their earning career, so that their declining years will never be without a *guaranteed* monthly income.

The experience of many nurses, after professional work has ceased, has shown that, regardless of other resources, an independent, regular monthly income of one's very own, even though small, contributes toward happiness, freedom from some of life's worries, and a degree of comfort not enjoyed by those wholly dependent on others.

A *guaranteed monthly income* is being built up today, in thirty-eight states and in three Canadian provinces, by nurses under the group annuity system of the "Harmon Plan" for registered nurses. This Plan was adjusted to the needs of the profession by the Special Committee appointed by the Joint Boards of Directors of the American Nurses' Association, the National League of Nursing Education, and the National Organization for Public Health Nursing, and approved by the Joint Boards of Directors of these three national nursing organizations at their meeting held in New York City the week of January 14, 1929.

Annuity Plan Open to All Registered Nurses

THE Plan is available to every registered nurse, regardless of where she works or lives. If you are a registered nurse, you are eligible for membership in the "Harmon Plan," and if you are still engaged in the profession, the Plan will be of help to you in building up a guaranteed monthly income for those years ahead after you have left the profession or have grown old. If you have already retired, you will find the Plan a sound way of investing previously accumulated funds.

The positions held by nurses enrolled in the "Harmon Plan" are representative, including principals of schools of nursing, directors, superintendents, instructors, head nurses, and so on, together with registered nurses who have but recently graduated. Also among the members are a number of the national, state, and district officers of nurses' organizations.

Membership Shows Wide Geographical Distribution

A REVIEW of contracts of the most recent one hundred members of the Plan indicates provisions that have been found both desirable and practical by representative nurses, and are also typical, as they cover a broad geographical distribution, including twenty-one states and two Canadian provinces, out of the thirty-eight states and three Canadian provinces in which there are members of the Plan. The distribution of these 100 members is as follows: 17 in New York, 12 in Massachusetts, 11 in Rhode Island, 10 in California, 9 in Ohio, 6 in Virginia, 4 in Michigan, 4 in Florida, and the remainder in Arkansas, Connecticut, Illinois, Iowa, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, Pennsylvania, Tennessee, Texas, Wisconsin, and the two Canadian provinces of Ontario and Quebec.

Of these registered nurses, 33 are engaged in private duty work, 30 are employed by hospitals, 20 are in visiting nurse associations, 11 are in public health departments, and 6 are employed by commercial, industrial, or manufacturing companies.

Many Ages Represented at Time of Joining

AGES at the time of joining the "Harmon Plan," include every age from 23 to 59, except that in this particular 100, no nurse happened to join at age 51; 20 joined before age 31, 44 at ages ranging from 31 to 40 inclusive, 25 at ages 41 to 50 inclusive, and 11 joined after age 50. While these statistics indicate that the majority of the hundred joined the Plan before they had been twenty years out of their training schools, it is also evident that age has not been a deterring factor, since 36 joined in their forties and fifties. Of these 100 nurses, 92 were single and 8 married at the time they enrolled in the Plan.

The records showing the different beneficiaries named in the event of the death of these 100 members before retirement are of particular interest as an indication of possible dependents of nurses. 35 designated their mothers as their beneficiaries; 26 designated sisters, 14 their "estate," 6 designated friends, 5 brothers, 4 fathers, 3 named nieces, 3 husbands, 2 designated mother and father jointly, one designated a son, and one a nephew. As a total of 20 per cent designated either their estates or simply a friend, it appears that at least one out of every five may have had no dependents at the time they joined the Plan.

The total amount of money that these 100 nurses are at present depositing in the Plan each month amounts to $1,125, the average monthly deposit being between $10 and $15. The smallest monthly deposit, the minimum accepted under the Plan, is $5 and the largest that any of this particular 100 nurses is depositing in the Plan each month is $50; 41 are depositing $5 monthly, 29 are depositing $10 monthly, 16 $20 monthly, 7 $15 monthly, 5 $25 monthly, 1 $30 monthly and 1 deposits $50 monthly.

Whenever they have larger amounts available, 6 of these 100 nurses are also occasionally investing single lump sums in what are technically called "single premium annuities," in order to supplement and increase the annuity income which they will receive under the monthly deposit system of the "Harmon Plan." The largest single investment of this character to date is $5,000, and the average is approximately $1,900.

The total annual amount of guaranteed annuity income, payable for life

to these typical 100 members, from the maturity dates selected by them, will be at the rate of $34,090 a year. Because this is a *group* annuity plan, the income payments to members may be expected to increase substantially over and above the contractual guaranteed amount mentioned above, by additional annuity income payments that may result from excess earnings in the administration of the group plan, or from surplus funds of the Association arising from any other source.

The amount of annuity held by each of these nurses varies widely according to the size of their deposits, their age at the time of joining the Plan, and the time they wish the annuity income to begin. The average annual amount of guaranteed annuity income which is being built up by the nurses included in this study, is $340.90. The largest annuity income which any of these particular 100 nurses is building up is at the rate of $1,425.60 a year.

Annuity Plan Has Special Features

THE "Harmon Plan" aims at creating, during the nurses' income producing years, maximum benefits for later in life when a regular monthly income, which is absolutely permanent, will be most needed; a guaranteed income for old age or retirement, when other financial resources may cease to exist. The Plan has all the important options and features, which the experience of many of the profession indicate desirable or essential to have, in an annuity held by a registered nurse. Among the features of the Plan, some of which are unique, are:

1. A permanent monthly income for the member's own use, which, once begun, continues throughout the remainder of her life, regardless of how long she lives.
2. No medical examination.
3. Convenience to the member in accumulating her fund and in her receipt of monthly income checks.
4. No forfeiture of any of her deposits.
5. Absolute safety for her investment.
6. In case of any emergency, the privilege of borrowing against or of withdrawing all of her deposits at any time that she may wish, previous to the beginning of the annuity payments to her, or of discontinuing further deposits, leaving those already made in the fund, and receiving at retirement age whatever annuity income they will provide.
7. In case of the member's death, the immediate cash payment to her beneficiary of the full credit balance on her deposits.
8. An organization through which funds from legacies, endowments, gifts, excess interest, or other sources may be administered for the members' benefit.
9. Membership in an association organized for the special purpose of assisting registered nurses in their financial provisions for their future, guided by their own trustees and officers chosen by the members themselves.

As in all systematic investment plans which are based on small and regular savings and investments, the earlier one starts the more one can accumulate through convenient monthly deposits. A pamphlet entitled "Annuities for Nurses," which gives full details, tells how to join this Plan, and shows what a number of other nurses are accomplishing, can be secured by any registered nurse simply

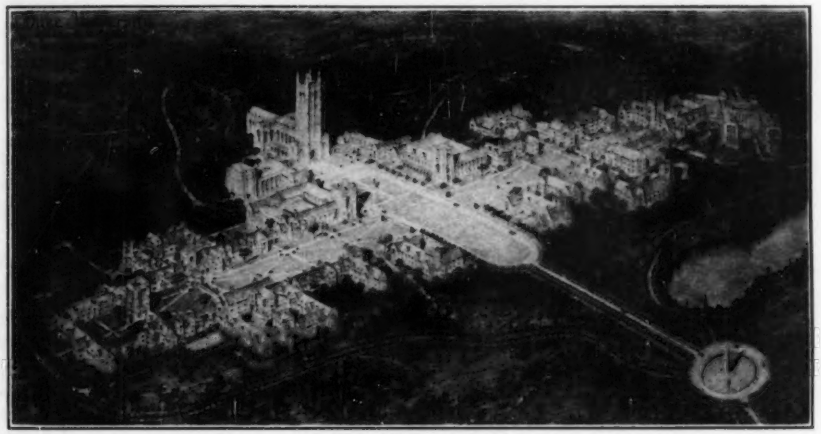
by writing to the Secretary of the Harmon Association for the Advancement of Nursing, 522 Fifth Avenue, New York, N. Y.

After you have finished reading the pamphlet "Annuities for Nurses," your coöperation in bringing it to the attention of other registered nurses will be appreciated, as the Joint Boards of Directors of the three national nursing organizations desire to have the details and advantages of the Plan known as widely as possible throughout the profession.

What Do They Tell on You?

The Duke University School of Nursing

ALTHOUGH the Medical School of Duke University and the Duke University School of Nursing at Durham, North Carolina, will not be opened until October, 1930, it was some three years earlier than that date when Dr. Wilbert C. Davison, the newly appointed Dean of the Medical School, asked the *American Journal of Nursing* for help in collecting a set of *Journals* for the new library. And recently the set has been completed, more than a year before the opening of the school.

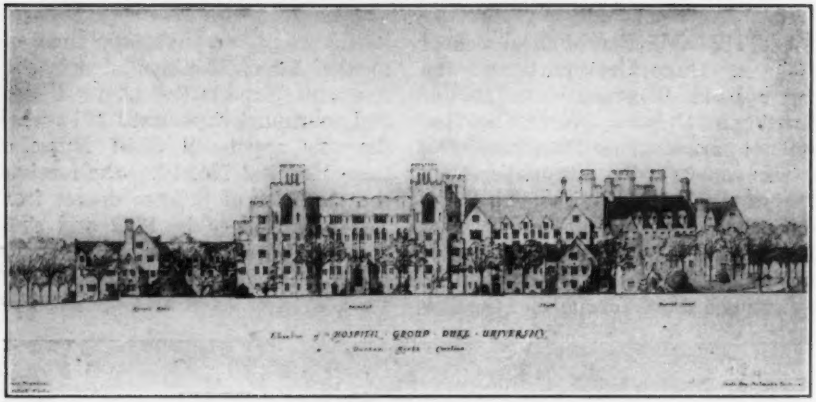


DUKE UNIVERSITY

Forethought such as this, and "long distance" planning, however, have been typical of the whole venture, for it was in May, 1929, that Miss Bessie Baker, R.N., B.S., was appointed Dean of the School of Nursing and Professor of Nursing Education. A native of Maryland, Miss Baker will take to her new position wide and varied experience. Graduating from the Johns Hopkins Hospital School of Nursing, she did head nursing and private duty for some years before she became assistant superintendent of nurses at the Women's Hospital in Baltimore. Two years later she went to the Johns Hopkins Hospital as Assistant Superintendent of Nurses and continued there until 1917 when she was appointed Chief Nurse of Base Hospital No. 18. She received the Bachelor of Science degree from Teachers College in 1922 and since then has been Director of Nursing in the Charles T. Miller Hospital in St. Paul, Minnesota, and Assistant Professor of Nursing at the University of Minnesota.

Her early appointment has made it possible for the plans of the nursing school, medical school and hospital to go forward together. It is significant that those concerned have seen the importance of that relationship in the laying of the foundations for this so necessary health project of the South.

The hope of a medical school at Duke University is not a new one. Before 1891, administrators of Trinity College (the forerunner of Duke University) and the State Medical Society had realized how sorely North Carolina needed facilities for medical education and for improving the health



HOSPITAL GROUP

Nurses' Home Hospital Staff Medical School

work in that district. Funds, however, were lacking, and the conviction that it would be

> inexpedient and adverse to the best interests of the profession to countenance the organization of a college of medicine in the state unless it can afford to its students advantages in every way equal to those afforded by the best schools in the large cities of our country [1]

had caused definite plans to be delayed until 1924 when, through the generosity of James B. Duke, the Duke Foundation was created for educational and charitable work in North and South Carolina. This includes funds for the erection of buildings for medical school and hospital and ample income for maintenance.

The School of Nursing will be an integral part of the University and the students will be selected on the same basis as other women students, namely intelligence, character and an acceptable high school certificate. This is in line with the ideals of the founder who in his deed of gift requested "that great care and discrimination be exercised in admitting as students only those whose previous record shows a character, determination and application evincing a wholesome and real ambition for life." [2]

Dr. Davison has stressed the fact that the student nurse will be a University student and will receive laboratory and classroom instruction and that her training will be similar in character to that of the medical interne in that she will be gaining practical experience in the care of patients. She will share the living conditions, the recreational and educational advantages of the University with the students of the Coördinate College for Women and tuition will be charged accordingly.

Tentative plans for programs of study include four groups: those wishing the diploma of Graduate Nurse, affiliated students from schools of recognized standing receiving certificates, candidates for postgraduate certificates, and candidates for the degree of Bachelor of Science in Nursing and the diploma of Graduate Nurse.

Duke University will grant the

[1] Way, J. H., M.D., and McBrayer, L. B., M.D., "Medical Colleges in North Carolina."

[2] Jenkins, J. W., "James B. Duke, Master Builder," New York, G. H. Doran Co., 1927, p. 294.

degree of Bachelor of Science to women who have successfully completed sixty semester hours in Duke University or an accepted college or university in addition to the three-year course leading to a diploma. As now planned, the sixty hours of college work may be completed either before or after the three-year course in the School of Nursing.

Clinical material will be available in the new Duke Hospital of four hundred beds and the out-patient department which is on the University campus. The services will include medicine, surgery, pediatrics, gynecology and obstetrics. It is planned also that there will be "the closest reciprocal relations between the medical department of Duke University and the local hospitals which are operated through the assistance of the hospital section of the Duke Endowment." [3]

Surely, the possibilities which are opened for nursing and medical education in this section, as well as for the community health, are almost limitless.

BESSIE BAKER, R.N.

[3] Rankin, W. S., M.D., Director, Hospital Section of the Duke Endowment, *Journal of the A. M. A.*, April 13. 1929.

A Good Example of Education in Service

OUR nurses are employed with a view to their training, knowledge, personality and adaptability. They are required to have special public health training or experience. The majority have had training at the Maternity Center Association, New York City. If they have not had this, time is allowed and arrangements made for them to avail themselves of it.

Every opportunity for educational advancement is given to them. Attendance at the annual New England Health Institute, short courses at the Summer School of the State University, attendance at lectures, etc., is always encouraged and advised. A three-day public health institute under our own direction is an annual event, with the staff taking an active part in the program. In addition our library is kept supplied with the finest and newest editions on health work. The public health nursing magazines are circulated, each nurse keeping the magazines for a two-weeks period. They are then placed on file in our office and are available to the other public health nurses of the State.—From Annual Report of the Division of Maternity, Infancy and Child Hygiene of the New Hampshire State Board of Health.

Teaching History of Nursing

CARRIE E. EPPLEY, R.N.

"HELLO, Brownie, where are you going? Oh, yes, you will have a wonderful time while I must go to that old history-of-nursing class. I do not see any value in spending our time hearing about some old women who lived years and years ago. Well, good bye, see you later."

How many of us hear student nurses express themselves in this manner! And might there not be truth in the students' statements? Do we, as teachers, present the subject in such a manner that the student may find it interesting?

First, the instructor must not only know the subject but she must enjoy reading it, talking it, searching for facts—all the necessary preparation for presenting it. The student reads and tries to digest the textbooks on history of nursing and wonders what it is all about, unless she has always liked the study of history. In this period of our professional development we are indeed fortunate in having such valuable textbooks as have been compiled by members of our profession and published for our benefit, but the students who may not have a natural liking for the study of history must be stimulated to a desire for such knowledge. If a teacher can *tell* the history of nursing as a continued story, I believe she can obtain satisfactory results. The students can be interested and they will respond with discussion.

We are much indebted and very grateful to those of our nurses who were prompted to have a yearly calendar published by the National League of Nursing Education. The calendars of 1922, 1923, 1924, and 1925 give the history and photographs of some of our pioneers. I have separated the leaves of these calendars and have hung them around the classroom, low enough to be seen easily. It is most gratifying to see the interest of the students in these pictures. They discuss what they have read and studied in connection with the picture. They are interested in the pioneer nurse, her uniform and mode of dress, and they especially admire the individual for what she has endured and sacrificed. They appreciate the fact that her success helps make it possible for members of the profession today to render better service to the sick and helpless and to render it intelligently and efficiently.

What Is Being Done in the Way of Mental Hygiene Education?

THE Mental Hygiene Section of the American Nurses' Association is endeavoring to be of service in advancing the preparation of the student nurse in the field of mental hygiene. We are trying to find out first of all how much mental hygiene education is now being carried out in (a) schools educating student nurses; (b) organizations providing a program of staff education. We believe that a great deal more is being done in this field than we are aware of. Hence, we are asking if nursing schools and nursing organizations would show their interest in our attempt to help evolve a better scheme of education by sending a statement in a few words telling us what they are doing in this particular field of nurse education.

Kindly address your reply to the Secretary of this Section, Anna K. McGibbon, Butler Hospital, Providence, R. I.

A Diet Kitchen in an Out-Patient Department

Origin and Present Function of the North End Diet Kitchen

BLANCHE COLLIER

MORE than fifty years ago, a group of kind and charitably disposed men and women established, in the crowded north section of Boston, an institution known as the North End Diet Kitchen, the original purpose of which was to give temporary aid to the sick poor of that district, by providing diets at a nominal cost. For years a kitchen was maintained where food was cooked and dispensed to sick people authorized by doctors, nurses and certain relief agencies to receive this aid.

During recent years the board of directors felt that funds so spent could be used to better advantage and in a manner more in keeping with modern methods. In 1923 an agreement was made with the Massachusetts General Hospital whereby the North End Diet Kitchen directors turned over to the hospital a sum of money to assist in establishing and maintaining a Diet Clinic in the Out-Patient Department. Later the original title North End Diet Kitchen was resumed.

NORTH END DIET KITCHEN

The Diet Kitchen occupies pleasant quarters on the top floor of the Out-Patient Department, consisting of waiting room-demonstration kitchen, equipped with gas stove, sink,

refrigerator, cupboards, blackboard, scales, etc., and an adjoining consultation room and laboratory. The Diet Kitchen is open on all clinic days, for ambulatory out-patients during the mornings, and for discharged ward patients in the afternoons. A special clinic for diabetics is held, two mornings a week; and an epileptic clinic, one morning. Others receiving dietary treatment include gastric, nephritic, obese, asthma, pernicious anemia and cardiac patients.

The Diet Kitchen coöperates with and is under the supervision of the medical department, the dietary treatment is in charge of a trained dietitian and an assistant dietitian, who have the help of a student dietitian and a student nurse.

Any patient whom the doctor finds in need of dietary treatment or instruction is referred to this department, either with a specific diet prescription or for a type of general diet. Each patient is treated as an individual and given a diet suitable to his medical condition. Actual food is used for teaching the patient what he is to eat and he is instructed how to measure the food; using ordinary household dishes, glasses, measuring cups etc. If a weighed diet is necessary, he is taught how to use food scales. Often it is also necessary to teach the patient how to prepare the foods advised.

Patients who come to the Out-Patient Department are of all types of intelligence, many nationalities, and varying financial status, which facts must be considered, as well as the problem of prescribing diets for those whose work or living conditions necessitate their carrying lunches or eating meals at restaurants or at irregular hours. Patients are given appointments to return at regular intervals to see if they understand and are following the diet or for change in diet if their condition warrants it. All patients are under medical care during their dietary régime which is only a part of their medical treatment.

The student nurses are assigned to this clinic for a three weeks' period, averaging two hours daily in the clinic. At present there are two student nurses. This averages approximately thirty-five students a year. This is primarily a period of observation; to learn from the dietitian the importance of diet, the necessity of careful teaching, and the need of close supervision of the patient. During this period the student nurse has an opportunity to take the dietary history of the patient, to calculate the diets, and to arrange these diets in menu form. She also demonstrates the preparation of food, and the portioning of this food into amounts easily approximated by the use of common household utensils. The students who have the privilege of three weeks in this clinic find it adds greatly to the theoretical knowledge received in the dietetics course.

Group Insurance in Milwaukee

ERNA KOWALKE, general director of the Visiting Nurse Service of Milwaukee, Wis., has announced the adoption of a group insurance program providing life insurance and sick and accident benefits for employees of the Service.

The contract is being underwritten by the Metropolitan Life Insurance Company.

General employees receive $1,000 life insurance each, together with sick and non-occupational accident benefits of $15 a week. The weekly payments will be made when an employee is unable to work due to sickness from any cause, or injury received while off duty.

Should an employee suffer total and permanent disability before age 60, the full amount of the life insurance will be paid, with interest, in monthly installments.

Now What Are You Doing?

MAY AYRES BURGESS

ONCE again the Grading Committee is preparing for its annual fall meeting, and is gathering material for its annual report. It is planning how best to utilize the 26 months of life which remain to it, and is looking back over the 34 months which have elapsed since it began its five-year program to see how much has really been accomplished. It pauses to think about the red book.

"Nurses, Patients, and Pocketbooks" was published just a year and a half ago. Nearly 6,000 copies have been sold. Now orders are coming in more slowly, and discussion of the book is beginning to die down. The book cost time and money. Were they well spent?

On two counts, almost certainly they were. The book put into printed form a great collection of material which nurses and others interested in nursing need to have available. It is a useful storehouse of information, and as such will probably be helpful for many years to come. Again, during these eighteen months the book has been widely read. It has interested a great many people, and started much active thinking. That also is worth while.

Yet is there not a third development which ought to come soon, if the book is to justify two years of research, and the expenditure of thousands of dollars, many of them hard earned nursing dollars? Hundreds of nurses have read the book, but having read it, some of them are putting it back upon the shelf. (How many weeks have passed since *you* have looked within the covers of *your* copy?) Soon new material will be coming out from the Grading Committee, with emphasis upon educational problems. Interest in the broader economic questions raised by the red book is in danger of being wiped out unless there can be a rather widespread conscious attempt to translate the story of the book into constructive action. When the report of such a study is published, three things should follow: People should read it; they should talk about it; they should do something about it. Isn't this the time to help nurses take that third step?

Over and over again we hear nurses say: "Tell us what you want us to do and we'll try to do it!" Theirs is a fair demand, surely; but so far we have let it go almost unanswered. Many thoughtful nurses have hesitated about starting committees to work, or trying to formulate lists of recommendations by themselves, because they have hoped that the Grading Committee would ultimately go on record with a full set of specific recommendations, covering everything which it has studied; and they have felt that it was only fair to wait until those recommendations were published.

It now seems probable that comparatively few specific recommendations of the type for which nurses in the field are waiting will come directly from the Grading Committee. According to its program, the Committee may properly gather facts and raise questions; but several of its members are genuinely doubtful as to how far it would be appropriate for them to go in urging specific recommendations. Is it not perhaps true that the nursing profession itself should be responsible for advising its members as to what use they should make of the material in the red book?

To some extent, recommendations will come from the Grading Committee,

but they will probably be few in number. The general attitude of the Committee is that if nurses want anything to happen as a result of the grading studies, they are quite competent to carry the responsibility for bringing it about.

Sometimes, perhaps before very long, the three national nursing organizations will feel it wise to go on record as recommending certain lines of action to their members, based upon those sections in the red book which deal with their particular fields. That would be a tremendous help to nurses, everywhere.

Pending such official national programs, however, might it not be helpful to all of us if we could find out what use is already being made of the material? The Grading Committee often receives letters, showing that individual nurses are not only thinking about the facts in "Nurses, Patients, and Pocketbooks," but are actually applying them to their own jobs. "I have been talking the matter over with our trustees, and we all agree that our hospital is too small to have a school. How much would it cost us to establish a graduate service?" "We are planning to add flexibility to our student service, by putting in more graduates on certain of our floors." "I am a private duty nurse, but I am willing to try floor duty if I can find the right hospital." "Where can I go to get courses which will bring me up to date." "Would it pay a public health nurse to take a position in a hospital, so that she could combine public health with hospital administration?" "I have just resigned because a nurse in my position ought to know more." So they come. Things *are* happening out in the field.

It would help the Grading Committee, and surely it would help the nurses, too, if there could be a general interchange of experience concerning ways for putting the findings of the red book into practice.

Private Duty Nurses: Have you worked out any new arrangements as to hours, which benefit both your patient and you? Have you found any scheme for securing more regular employment? How do you manage to keep up to date in your nursing technics? Have you tried floor duty recently? How did it work?

Superintendents of Nurses: Are you going to write an annual report this year? Are you getting better acquainted with your trustees? Are you learning how to talk the language of the superintendent of the hospital and of the trustees so that you dare speak frankly and yet know they will understand? For example . . .?

Heads of Schools: Have you raised your entrance requirements, so as to select better educated, better quality students? Are they sufficiently mature? Are you managing earlier to weed out those who should not have been admitted, so that all your graduates are nurses you can be proud of? Are you supplementing your student nursing by graduate nursing on your heavier services? How do you manage to make your graduate floor duty nurses respected and envied by your Senior class?

Instructors, Supervisors, Head Nurses: Are you beginning to think of yourself as a teacher not just an administrator? Do you know more about teaching methods than you did a year ago? Have you taken any courses? Read any professional books? Attended any conventions?

Public Health Nurses: Are you a good bedside nurse in the modern sense of the word? How are you keeping up to date on new technics? By going back into floor duty for a few months? Could floor duty be as

attractive to you as public health? Have you found out whether you could make it attractive to someone else if you happened to be running it? Do any of the public health principles apply? Should the hospital have a close connection with public health nursing? If so, could you help establish it with your present knowledge of hospital problems? Do you know more about your profession than you did a year ago? How did you learn?

All Nurses Everywhere: What are you doing to teach patients about nursing? How are you reaching the newspapers? the women's clubs? Have you any local contact with the medical organization which is proving especially helpful? Do you know the principal of the high school? How did you convince him that nursing should be recommended only to his best students? Do you know any parents of high grade, 18-year-old daughters? Can you make them fervently wish their daughters might be allowed to enter nursing? How many more members have you in the District this year? Did all this year's graduates join? Is the District worth belonging to?

Once one begins asking questions, there is no end. Almost every page of the red book suggests another. If we knew what was really being done, the list of recommendations would write itself. Is there any way in which we could find out the specific things which nurses are doing, and which other nurses might well do, to carry on the work of the red book?

Nursing Needs of New Medical Center Studied

GROUND has recently been broken for the new New York Hospital-Cornell Medical school Center, the plans for which include not only a residence for nurses but a separate unit for the school of nursing.

Early in September, Ethel Johns began her work as Director of Studies for the Committee on Nursing Organization of the New York Hospital, with headquarters at 370 Seventh Avenue. It is peculiarly interesting that the Committee has been formed, since it further supports the fact that directors of hospitals and medical schools are more and more coming to realize the basic position of the nurse in the planning of the whole structure of hospital—medical school—nursing school.

The Committee is known as the Committee on Nursing Organization of the New York Hospital. It is a Committee of the New York Hospital Nurses' Alumnae Association and its members are: Mary Beard, Chairman, Anna L. Reutinger, Secretary, and Lydia E. Anderson. Honorary members are: Dean Annie W. Goodrich of the Yale University School of Nursing and Miss Jordan, Directress of Nurses of the New York Hospital. There is also an Advisory Committee which includes other persons interested in many branches of nursing. They are: Dr. May Ayres Burgess, Nina D. Gage, Mary M. Marvin, Mary M. Roberts and Katharine Tucker.

Miss Johns, Director of Studies for the Committee, is a graduate of the School of Nursing of the Winnipeg General Hospital and has done graduate study at Teachers College, Columbia University. She was for two years superintendent of the McKeller General Hospital at Fort William, Canada,

and for four years held a similar position in the Children's Hospital in Winnipeg. During three of the five years while she was Assistant Professor in the Department of Nursing and Health in the University of British Columbia, she was also Director of Nursing at the Vancouver General Hospital of a thousand beds. She has

ETHEL E. JOHNS, R.N.
(Photograph by Bachrach)

made a study of the status of the negro woman in nursing in the United States and for the past four years has been Field Director attached to the Paris office of the Rockefeller Foundation. During this time she assisted in the development of nursing service in Hungary and Roumania.

It will be seen that Miss Johns brings to her new position wide practical experience in and personal knowledge of hospital and nursing work, both on this side of the Atlantic and abroad. Her appointment as Director of Studies is indeed timely.

A Magnificent Gift

THE International Congress of Nurses which has just been held in Montreal saw a renewal of the marvellous gesture of all the nurses of the United States who gave the building to the Florence Nightingale School. Raising a living monument to their sisters who died in the great war, the nurses of the United States wished to complete it, and to that end made a supreme effort to collect the amount necessary to construct the second wing which was lacking. The sum of $28,000 was transmitted to Mesdames Hervey and Le Rossignol for the school and more has since been added.

This concerted effort of our sisters in the United States has put us under new obligations of gratitude, gratitude toward those who gave their lives for humanity and infinite gratitude to those who have confidence in us, judging us worthy of the heritage of courage and sacrifice left by those sisters who fell on the field of honor.

As a former pupil of the Florence Nightingale School, conscious of the honor done us and the responsibility it involves, I speak as interpreter for not only my fellows, but also for all the young French girls who have responded to the appeal of suffering humanity, to express in a fervent "Thank you" our gratitude to our sisters in the United States.

E. SELTZER.

Translated from the *Bulletin de la École Florence Nightingale*, Bordeaux, October, 1929.

An Administrative and Educational Opportunity

IN February, 1929, the New York City hospitals were reorganized and a Department of Hospitals with a Division of Nursing was created. Marian Rottman has recently been appointed Director of the Division of Nursing. In this position, Miss Rottman is the official directly responsible for the nursing service of twenty-six institutions and eight registered nursing schools, including one for colored nurses and one for male nurses, also two institutions registered for student nurse affiliations and several schools for the training of attendants. Approximately 17,000 beds are represented in the twenty-six institutions.

Miss Rottman is a graduate of Bellevue (1912) so that her understanding of the workings of New York City hospitals began in her training days. Soon after graduation she accepted the position of Assistant Superintendent of Nurses at the Robert Long Hospital, Indianapolis, Indiana, where she remained for one year, returning to Bellevue in 1914 to equip, open and organize the nursing service of two new 700-bed surgical pavilions. In 1918 she was sent overseas and served as Chief Nurse of Evacuation Hospital Number 1, until the end of the war. Probably in no situation were Miss Rottman's courage, endurance, resourcefulness and ability to organize and lead, better displayed. She received an army citation from General Pershing for "conspicuous and exceptionally meritorious service."

On her return to this country, and following a civil service examination in which sixty-four other candidates participated, Miss Rottman was appointed Superintendent of the Johnston Emergency Hospital of the City of Milwaukee. She occupied this

MARIAN ROTTMAN, R.N.

post for two years, then entered Teachers College, Columbia University, for a year of professional study. In 1922, the Mount Sinai Hospital of Milwaukee sought her services to reorganize its school of nursing and fill the position of Principal of the School and Superintendent of Nurses. Miss Rottman remained at Mount Sinai until 1925, during which time she organized the Central School of Nursing of Milwaukee. In 1925 she was called again to her own school, this time as Director of the Nursing Service and Principal of the Nursing Schools of Bellevue and Allied Hospitals, a position which included the direction of the nursing service of four hospitals and three schools of nursing; an excellent training for the office she now holds.

Miss Rottman's activities have never been confined to the immediate

position which she occupies. Broadly interested in the problems of nursing, eager to give her share to public and group professional movements, she has taken an active part in the work of local, state and national nursing associations. Since 1924, she has served as a member of the Board of Directors of the National League of Nursing Education, first as a director and for the past four years as treasurer.

Fundamentally Miss Rottman is an organizer and administrator of the creative type. Nonetheless is she an educator, as her past and present record amply demonstrates. Big jobs do not disturb her, rather they offer the stimulation and challenge which best satisfy her temperament and capacities. Gifted with enthusiasm and imagination, yet never losing sight of the practical, Miss Rottman is singularly well qualified for the enormous and demanding new task which she has just undertaken. May she have every success!

Wise Use of Books

EDNA L. FOLEY, Superintendent of the Chicago Visiting Nurse Association, shares with us some valuable suggestions on the use of books which should be useful to individuals and to instructors in schools of nursing, as well as to public health administrators and supervisors. A Library Endowment Fund provides a fairly large supply of good reference books for the main office. There is a smaller supply at each of the eleven sub-stations. Miss Foley writes:

"In books like Dr. Cabot's 'Social Service and the Art of Healing,' which we ask every nurse who comes to us and every student to read through, we put a list of paragraphs and pages which they cannot afford not to read very thoroughly and carefully. Olsen's 'Improvised Equipment' has recently received its set of references and several other books have typed lists of references pasted just inside the cover. In sending Blatz' 'Parents and the Pre-School Child' out to all of the sub-stations, we have pasted in the cover the following list of references.

OF SPECIAL INTEREST

'Parents and the Pre-School Child'—Blatz

Page 13. Changed Material Conditions.
Chap. 2—Appetites and Habit Formation.
Page 28. Appetites: Rhythms.
43. Routine for Freedom.
47. Eating Habits.
51. Consistency of Food: Flavor.
76. Day Sleep.
83. Bedtime Confidences.
122. Sleeping Alone—Small Furniture, Pictures.
136. Values of Play.
156.
157. Sex Instruction.
164. Mother's Responsibility.
188. Self-Reliance.
189. Anger.
204. Legitimate Fears.
212. Legitimate Risks.
214. Moral Support.
Chap. 10—Temper Tantrums (excellent).
Page 226. Self-Control.
231. Emotional Irritability and Illness.
236. Elementary Conflict Situations.
247. What Is Mental Hygiene? (Whole chapter.)
278. Duties of Parents: Socialization Education, Emancipation of Child.
280. Discipline.

"For nurses who constantly work with little children or with parents, this book is invaluable. Good texts, examples and helpful advice can be found on almost every page.

"'Habits are useful tools, but need reshaping to serve their owner in his particular stage of development and kind of environment.'"

Out of the Mail Bag

"THERE is so much that is splendid and worth while in each issue. My husband reads the *Journals* as religiously as I do; thought you would like to know that not a nurse, alone, finds them interesting."

Pennsylvania. G. R. D.

"I once read it as a duty, but now I prefer it to anything that comes to my hand to read. I continue to get inspiration from it from month to month."

Arkansas. R. R.

Nursing by Religious Orders in the United States

Part V—Deaconesses, 1855–1928

ANN DOYLE, R.N.

"I commend unto you, Phoebe, our sister, a Deaconess of the Church."—Romans XVI: 1.

ED. NOTE.—Included in this paper are Episcopal, Methodist, Evangelical, and Mennonite Deaconesses. Failure to include any other denominational groups has been due only to lack of success in finding any material relative to them. The editors will be pleased to have such omissions called to their attention.

The Episcopal Deaconesses

THE next movement to establish a group of nurse religious in order of time was by the Episcopal Church.[1] The Diocese of Maryland may lay undisputed claim to the honor, an association known as the "United Deaconesses" having begun their work there in 1855.[2]

The Order of Deaconesses of the Diocese of Maryland originated in St. Andrew's Parish, Baltimore, under the ministry of the Rev. Horace Stringfellow. In 1855, two ladies gave themselves to the work of ministering to the poor, and became residents of St. Andrew's Rectory for that purpose. With the sanction and approval of the Bishop of the Diocese, a house was secured and opened under the name of St. Andrew's Infirmary.[3]

Practically no record is to be found of this group of early nurse religious except a fragment here and there. Neither is there any record of their founder other than the bare entries of his name in the clergy lists and his simple, terse reports to his bishop. And these, strangely enough, as printed in the Convention Records, do not mention the Deaconesses nor the Infirmary.

The inspiration to found this hospital and place it in the care of a consecrated group came, as in the instance of the Pittsburgh Infirmary and the Lutheran Deaconesses, from Kaiserswerth.

The Infirmary owes its origin to the Rev. Horace Stringfellow, Rector of St. Andrew's, in that part of Baltimore called Old Town. He had visited Kaiserswerth. The zeal kindled there was imparted to a widowed lady of Boston, Mrs. Tyler, who was readily persuaded to attempt with him the founding of something like Fliedner's Institution.[4]

Accompanied by several others who shared her spirit, she removed to Baltimore, and relying on an honest promise of freedom from all consideration of monetary matters, undertook the direction of what was intended to be "a place of refuge for the destitute sick, and also of quiet religious nursing for sick members of the Church desirous of and able to pay for the advantage."[5]

Neither Mrs. Tyler nor any of her companions had had any training as nurses. They had, as many religious women before them, the will to serve God through ministering to the sick poor and the neglected orphan. And their efforts were rewarded with success.

This was entered on without any previous training. What began as a parish work was soon established as The Infirmary of the Diocese of Maryland. As had been purposed, the Christian women who had undertaken it offered themselves to the Bishop for the charitable ministrations of the Church: They were by him organized as Deaconesses, and received a rule, recognized to be only tentative.[6]

[1] Wheeler, Rev. Henry, "Deaconesses Ancient and Modern," p. 235.

[2] Rich, Lawson Carter, "The Deaconesses of the Church in Modern Times," *The Churchman*, Vol. 95, p. 653.

[3] Potter, Rev. Henry C., D.D., "Sisterhoods and Deaconesses at Home and Abroad," p. 118.

[4] Brand, William Francis, "Life of William Rollinson Whittingham, Fourth Bishop of Maryland," Vol. 1, p. 457.

[5] *Ibid.*, p. 458. [6] *Ibid.*, p. 458.

The exact date of their consecration is not known (to this writer), but the fact that Bishop Whittingham gave episcopal recognition and approval to the undertaking is evidenced by the following entries in his Journal:

November 4, 1856. Morning. I visited the Infirmary in Exeter Street and formally accepted the Rule of it, as offered by the Associate Sisters in their Instrument to that effect dated November 3.

Notified them of such acceptance, and of the appointment of Rev. William C. Crane, Presbyter, as Rector or Warden by formal Instrument.[7]

St. Andrew's Infirmary was located at 64 S. Exeter Street.[8] Here the Deaconesses worked "with good results" until February 9, 1858, when through the efforts of Bishop Whittingham, a consolidation was effected with another charity, the Church Home (for aged and infirm persons) and formed what is the present Church Home and Infirmary of Baltimore.

Father Stringfellow did not long remain with the young Order and its Infirmary. Sword's Almanack records the fact that in 1857, he went to St. Martin's Parish, Hanover, P. O. Verdon, Virginia.

The founder of the Infirmary, called elsewhere, left his Institution to the fostering care of others, the large and well placed buildings of a dissolved Medical College were purchased for the Church Home, together with the Diocesan Infirmary, and here, under the government of a large body of Trustees, the combined charities were placed under the care of the Deaconesses.[9]

The First Annual Report of the Church Home and Infirmary, dated December 6, 1858, tells the story of the consolidation:

On June 15, 1857, . . . the propriety of purchasing the Medical College property[10] was under consideration. . . . On September 23, the Board authorized the purchase, at a sum not exceeding $23,000, in fee simple. . . . October 2, the purchase was consummated for $20,000, subject to a groundrent of $150 per Annum. . . . October 7, a committee on repairs was appointed who immediately entered upon the duty of putting the buildings in suitable condition for its uses. . . . On October 28, a committee was appointed to confer with the parties connected with St. Andrew's Infirmary, with reference to their taking charge of the Home, which committee reported on January 10, 1858, that final arrangements had been completed by which the internal arrangements of the Institution would be in charge of the Deaconesses of the Diocese of Maryland. . . . On February 9, 1858, the new Infirmary was taken in charge by the Deaconesses, they removing their patients (the former inmates of St. Andrew's Infirmary), and merging them in one work of Charity.

The report finishes with: "The *Internal affairs* of the *house* could not have been better nor more economically conducted than they have been by the Deaconess in Charge."

Included in the report is a census for the first year:

December 2, 1858

No. of patients recei'd:		Ma's	Fem
From St. Andrew's Infirmary	20	12	8
From Church Home.....	16	4	12
Since Feb. 9.....	117	37	80
	153	53	100

The physicians, Drs. F. Donaldson, James A. Reed, and Robert Atkinson[11] report that it affords them great pleasure "to acknowledge the valuable and efficient assistance they have had from the Deaconesses: who have been indefatigable in their attentions

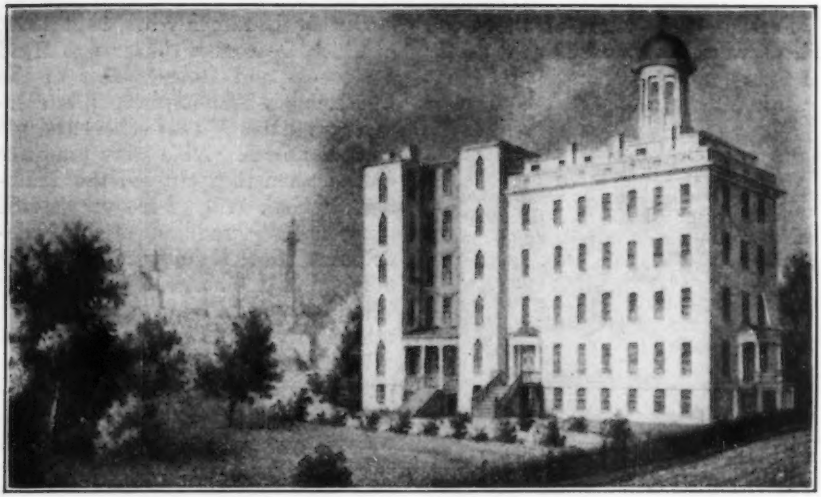
[7] Letter from Bishop Paret to Mr. L. C. Rich, and published in the *Churchman*, Vol. 95, p. 662.

[8] In some of the historical sketches of the Church Home and Infirmary it is stated that St. Andrew's Infirmary was located on High Street. Entries in the Bishop's Journal would seem to indicate that this is wrong.

[9] Brand, W. F., *op. cit.*, p. 459.

[10] Medical department of the Washington University, which later merged with the College of Physicians and Surgeons of Baltimore, and is now a part of the University of Maryland.

[11] Drs. Donaldson and Atkinson were attached to the Church Home and Dr. Reed was the physician at St. Andrew's. The Convention Records show Dr. Reed as the lay delegate from St. Andrew's Parish.



THE CHURCH HOME AND INFIRMARY, BALTIMORE, MARYLAND, IN 1859
(From Collins Historical Sketch)

to the sick and dying, nursing them and administering at all hours in every way to their comfort and relief. Thus they are daily working effectively this noble Church Charity." [12]

In addition to caring for the patients in the hospital, the Deaconesses also did some visiting nursing in the homes of the sick poor in the neighborhood.

The Deaconesses continued in charge of the hospital until 1864, when they were replaced by the Sisters of the Good Shepherd, the early Deaconesses forming the nucleus of this group.[13] Mrs. Tyler was always called the "First Deaconess."

It is interesting to note that the Report of the Church Home and Infirmary of 1863 mentions the possibility of a training school for nurses.

It is to establish there a training school for nurses, where Christian women, who desire to devote themselves to such a calling may find a home, and gain experience which is so necessary for its judicious and faithful exercise. This has already been done to a limited extent, but it is the wish of the Trustees to establish this as an integral part of their work. It is believed that such a central home for nurses would be a great blessing to the Home itself, to the women who might be instructed there, and to the community at large, who would be supplied with carefully trained and responsible nurses, whose fidelity can be vouched for by the physicians and other officers of the institution.

From the reports of the Church Home and Infirmary it would appear that there had been an interim when there were neither Sisters nor Deaconesses at the hospital. For example, the report of 1866 states that the Sisters of Good Shepherd have volunteered to take charge of the hospital for three months, "at the end of which experimental period the Sisters were willing to withdraw in case the Trustees should prefer to fall back upon the old arrangement."

[12] This First Annual Report of the Church Home and Infirmary which seems to be the only one in existence, is owned by the Maryland Historical Society.

[13] Rich, Lawson Carter, "The Deaconesses of the Church in Modern Times," *The Churchman*, Vol. 95, p. 662.

Further, the Sisters of the Good Shepherd were organized by the pastor of St. Luke's Parish for work in that Parish. The report of 1866, continues:

As this movement is a very important one, and has already been attended with great advantage to the institution, the Board of Trustees desire to place on record their deep sense of the very valuable services which were rendered in their great emergency by this Association of Christian women. In the hottest part of the past trying summer, the Sisters freely relinquished their usual vacation, went to the Home in sufficient force to take charge of its affairs, gave themselves up not only to the work of nursing, but with their own hands cleansed and purified the building from top to bottom, putting every room and ward in good order, and establishing a degree of neatness, order and economy throughout, which cannot but be gratifying to the friends of the institution.

It does not seem reasonable that the hospital could have gotten into the state described while the Deaconesses were still in charge.

This has been the only group of Deaconesses in the Episcopal Church devoted to nursing with the exception of the Deaconesses of Long Island.[14] None of the Deaconess training schools have seemed to stress nursing. Deaconess Anna G. Newell writes:

Our emphasis at St. Margaret's has been more on the line of religious education and the experience in the Hospital has not been a required part of the course but elective. Some of the women who have trained as Deaconesses have been registered nurses at the time of their entering training but I believe none of these have pursued the profession of nursing as Deaconesses. Personally, I am very interested in the problem of training nurses at the Church Center to take the supervision of our Church Training Schools for Nurses. I think both the nursing profession and the spiritual profession of women would profit by such a combination of training. . . .[15]

[14] This group of Deaconesses became the Community of St. John the Evangelist and will be treated in the article dealing with Sisters.

[15] Letter from Deaconess Anna G. Newell, Deaconess in Charge, St. Margaret's House, Berkeley, Calif., to Mary M. Roberts, R.N., Ed. *A. J. N.*, May 9, 1929.

During the fifteen years, 1913–1928, in which Deaconess Carter was Head Deaconess and Housemother of the Philadelphia Training School, but sixteen graduates of that school became trained nurses. Nine were graduate nurses when they entered the Training School. All were registered nurses. Two graduates of the Philadelphia School are now in schools of nursing as students—one is at the Children's Hospital in Boston, the other in the Hartford General.[16]

The Episcopal Eye and Ear Hospital, Washington, D. C., is under the direction of two Deaconesses—Deaconess MacDonald, a graduate of the Johns Hopkins Hospital, Baltimore, and Deaconess Crane, who while not a nurse is an able, understanding ally. This is, as far as could be discovered, the only hospital in charge of Deaconesses.

The contribution to nursing by the nurse religious of the Episcopal Church, except in the instances enumerated, has been made by the several Sisterhoods.[17]

The Methodist Deaconess

To Lucy Rider Meyer, belongs the honor of having established the first training center for nurse Deaconesses in the Methodist Church of America.

On October 20, 1885, Mrs. Meyer and her husband, the Rev. J. S. Meyer, rented a house in Chicago, 19 Park Avenue, and opened the Chicago Training School for Missions.

Mrs. Meyer was a graduate in medicine[18] (it having been her pur-

[16] Letter to Miss Roberts, February 27, 1929.

[17] The nursing Sisterhoods or those which have contributed to nursing will be treated in a subsequent issue of the *Journal*.

[18] Mrs. Meyer graduated from Oberlin College, and later studied medicine, obtaining her degree of M.D. from a medical college which afterward became a part of the Northwestern University.—Golder, "History of the Deaconess Movement," p. 317.

pose to enter the Foreign Missionary field, when the death of a friend changed her plans) and during the summer vacation months of 1886 and 1887 she and her students worked among the sick poor in the crowded sections of Chicago. The Deaconesses visiting in the homes found many patients who should have been receiving hospital care or continuous skilled nursing. But there were no skilled nurses to send in to the homes and hospital beds were too few.

Being a physician, Mrs. Meyer more keenly realized that good hospital care was essential to the cure of many of the conditions which her students came upon and so she added another burden to her already very great one and began to interest influential Methodists in the idea of founding a hospital in Chicago.

In 1888 a group of men, feeling that the time had come to found a hospital, obtained a charter, "the object for which . . . is to maintain an hospital in the City of Chicago, Illinois, for the gratuitous treatment of the medical and surgical diseases of the poor." They called it Wesley Hospital.

The hospital found its first home in four rooms provided by the Missionary Training School. The first patient, a woman, was received on Thanksgiving Day.[19] This hospital, therefore, was the first in America under the charge of the Deaconesses of the Methodist Episcopal Church.

By February, 1889, the hospital had become so successful that larger quarters had to be found. In the spring of 1899, an agreement was entered into whereby the management of the hospital and the training school was turned over to that organization for five years.[20] Here all of the early

MRS. LUCY RIDER MEYER
(From "History of the Deaconess Movement," Golder

Deaconesses were given their nurse training, the School of Nursing having been established in 1888.

In the first decade following the founding of the Deaconess work, every Deaconess received some nurse training and many became trained nurses but this is no longer the case as each Deaconess is specially trained for the type of work she is best fitted to do, such as social service, religious education, kindergarten work, and the like, and those who elect nursing are trained specifically for that profession.

Further, the trend in Deaconess work has been toward religious education and social service and away from nursing, particularly institutional nursing, it being felt by some that the demands of present-day nursing and nursing education are so great as to

[19] Thirty-eighth Annual Report of the Wesley Memorial Hospital, Chicago, 1927, p. 22.
[20] *Ibid.*, p. 23.

retard the development of the religious side of the Deaconesses' life—"the devotion of Mary was often put aside for the service of Martha." [21]

But that the nurse Deaconess is felt to be an important factor in Deaconess work is evidenced by the following excerpt from the Report of the General Conference Commission on Deaconess Work to the General Conference, May, 1928:

> It is to be regretted that more Deaconesses are not being recruited at present from the nursing profession. In the past a number of the most noted Deaconesses have come up from the ranks of the nursing service and the church makes provision for the nurse-deaconess relationship by favoring the candidate with special examinations in only three subjects in addition to the regular course in the School of Nursing. The Commission believes there is a large and expanding field of service for the Deaconess-nurse and recommends that larger emphasis be placed on this growing opportunity for service. It is of interest to note that every licensed Deaconess serving in Germany is a graduate nurse and that this policy has become thoroughly established as a practice among all Deaconesses of Europe. In the United States only 124 of 810 active Deaconesses are listed as serving in hospitals but several more are graduate nurses serving in other capacities.

Deaconesses have made a large contribution to the development of the Methodist hospitals; to the development of student nurse education; and to the professional development of nursing. The General Board of Deaconess Work controls and operates seventy-nine hospitals of which, thirty are directly under Deaconess management and supervision. One hundred and twenty-four registered nurse Deaconesses are engaged in these hospitals in caring for the sick, in hospital administration, and in student nurse education. In addition to these, there are many doing parish visiting, supplementing the work of the visiting nurses, caring for the sick aged—a duty which has been left almost entirely to the nurse religious—or the orphan.

[21] Golder, C, *op. cit.*, 133.

There is not space to trace the development of the founding of each of the hospitals, fascinating and romantic as each story is, nor to give even the briefest mention to the work of the many outstanding Methodist nurse Deaconesses. Practically every state association feels the influence of one or more of these splendid nurses.

Mention must, however, be made of one or two of the historic hospitals. Christ Hospital, Cincinnati, founded in 1889, through the generosity of Mr. James M. Gamble, was the second Methodist hospital in the United States to be placed under Deaconess care.

Isabelle Thoburn, sister of Bishop Thoburn, one of the founders of the Deaconess movement in this country, was the first superintendent. Sister Louise Golder, the first German Methodist Deaconess, and one of the founders of the German Branch of Deaconess work in the United States, was one of its first students.

The high standing of Christ Hospital from the very beginning, despite the fact that it was begun in poverty, is attested by an article in the *Cincinnati Lancet Clinic*, April, 1890:

> Christ Hospital is a recently opened charity in the northwestern portion of our city that is destined to be a real godsend to the poor of that district. . . . The Superintendent is Rev. Dr. Weakley, a man bountifully provided with genuine, practical common sense.
>
> The attendants and nurses are a sisterhood of Protestant Deaconesses, cultured women who have voluntarily sought this life in order to do the most good in the best way to those who are unable to care for themselves.

Dr. C. G. Comegys, the Medical Director, is spoken of in high terms. The purpose of the hospital to minister to all classes of patients is clearly explained, and the plans to open a

EIGHTH ANNIVERSARY GROUP (1896) CHRIST HOSPITAL, CINCINNATI, OHIO

dispensary and a clinical teaching department are discussed.

At first difficulty was experienced in securing a head nurse. Miss Beardsley, a graduate of the Illinois Training School connected with the Cook County Hospital, served in that capacity temporarily and "gave efficient service in planning and organizing. The place is now (April, 1890) filled by Miss M. Thoburn, also a graduate of the Illinois Training School."

In common with most nurse religious, these nurse Deaconesses did visiting nursing both before and after patients had been admitted to the hospital.[22]

Christ Hospital has rounded out forty years of service to the sick. Its School of Nursing, begun in 1889, has contributed many members to our profession, as well as training many Deaconesses for the service of the Church, for it was an all Deaconess school until 1903. Miss Alice P. Thatcher is the present Superintendent.

Bethesda Hospital, Cincinnati, as has been stated in a previous paragraph, owes much of its success to the devoted labors of Sister Louise Golder. Organized in 1896, it has continued to grow and its influence for good is to be felt wherever its students are to be found. The School of Nursing was organized in 1914.

The development of hospital and nursing work under the auspices of the Methodist Church in Montana and the far West may also be charged to the

[22] Reprinted in "Labors of Love," Vol. 24, June, 1925, p. 6.

MISS LOUISE GOLDER
(From "History of the Deaconess Movement," Golder

devotion of a nurse Deaconess, E. Augusta Ariss, Deaconess Nurse Superintendent of the Montana Deaconess Hospital at Great Falls, Montana. Miss Ariss has always taken a leading part in the development of nursing in Montana and the far West. She was president of the Montana State Nurses' Association from 1921 to 1927. She has been president of the State Board of Nurse Examiners and Training School Inspector.[23] Permelia Clark and Grace Linfield, nurse Deaconesses, associates of Miss Ariss have also served on the Board of Nurse Examiners of Montana.[24]

Other historic hospitals which should at least be mentioned are Sibley Memorial Hospital, Washington, D. C. (1889); Deaconess Hospital, Boston (1889); Asbury Hospital, Minneapolis (1891).

The education of the student nurse has always been an important part of the Deaconess Hospital program. Of the seventy-nine hospitals under the control of the Board of Deaconess Work, sixty-nine have schools of nursing. Practically all of these schools are registered by the several states in which they are located.

Where a hospital is too small to provide clinical material sufficient to satisfy the demands of the State Board requirements, suitable affiliations are made with larger hospitals.

Deaconess hospital schools of nursing have set for themselves high educational requirements. In practically every instance the entrance requirement is higher than that demanded by the state in which the school is located.

Seven of the Deaconess hospital nursing schools have some type of university or college affiliation.[25]

Methodist Deaconess nurses are always members of the state and local nursing organizations. Since they use the title "Miss" or "Mrs." before their names, it is impossible many times to differentiate them from the lay nurse members. Similarly, they have become registered nurses as soon as registration became the law in the state where they happened to be. Many times they have been among the first, as for example, Miss Deen in Florida; Miss Ariss in Montana; Miss Dueker in Nebraska; Stella Corbin in New Mexico; and Abbie J. Mills in Oregon.

No record of Methodist Deaconess work should be written without mentioning, in respectful remembrance, Mrs. Anna Wittemeyer, Mrs. Susan

[23] Who's Who, *A. J. N.*, January, 1927, p. 44.

[24] From data collected by questionnaire sent out by the *Journal*, January, 1929.

[25] Compiled from reports from the various and several Deaconess hospitals and from state and local nursing associations.

D. Fry, and Mrs. Jane M. Bancroft Robinson. These women, while not nurses, made possible in various ways much of the work which the Deaconess nurse has been able to do. Mrs. Wittemeyer, affectionately called the "Amalie Sieveking of American Methodism," did nurse in the Civil War, and Mrs. Fry, studied nursing methods at Kaiserswerth.

The Evangelical Deaconesses

VERY important in the history of nursing by religious orders in the United States had been that group of Deaconesses known as Evangelical Deaconesses, in which are included members of various Protestant churches. While it is manifestly impossible to give detailed accounts of all of the groups an attempt will be made to mention them.

The Evangelical Deaconess Society of St. Louis was organized in 1889 by the pastors and members of the German Evangelical churches and was incorporated in 1891.[26] The purpose of this association was to "take care of the sick poor. . . . Such care of the sick poor is to be given by Deaconesses, *i.e.*, by theoretically and practically trained nurses in the spirit of Christian love and mercy. . . ."[27]

Through the generosity of Mrs. Mebus, a widow, a house was provided to be used as a hospital.[28] The first Deaconesses were two trained nurses, graduates of St. Luke's Hospital, then under the charge of the Sisters of the Good Shepherd. They were Mrs. Katherine Haack, a minister's widow, and her adopted daughter, Lydia Daries. These Sisters were known in religion as Sister Katherine and Sister Lydia.

[26] Trenholme, L. I., "History of Nursing in Missouri," p. 38.
[27] "Principles of Deaconess Work," p. 87.
[28] *Ibid.*, p. 88.

The first four deaconesses, Evangelical Deaconess Home and Hospital, St. Louis, Mo., 1887. Standing: Sisters Sophie, Charlotte, and Lydia. Seated: Sister Katherine, first Deaconess in charge.

In 1891 the Sisters organized a School of Nursing. This school is an accredited one and is, so far as is known, the only all-Sisters training school conducted by Deaconesses.[29]

This school of nursing has been a very important one and has trained many Deaconesses who have done splendid work in the nursing field. It has an entrance requirement of full four years high school, which is higher than the law at the present time demands. All of its graduates become registered nurses. The present Superintendent of Nurses, Sister Sophie Hubeli, R.N., was the first Deaconess to be registered in Missouri. The School Faculty are all members of the State and National Associations.

The Deaconess Home and Hospital of Cincinnati, the oldest of the interdenominational group, was organized in 1888.

In the spring of that year a number of pastors of different denominations of Cincinnati and vicinity met for conference in the Evangelical Zion's

[29] Trenholme, L. I., *op. cit.*, p. 38.

Church, and on June 14, they established the "Evangelical Society for Deaconess Work." The society was afterwards incorporated under the laws of the state of Ohio as "The Evangelical Protestant Society for Deaconess Work and the Care of the Sick."

Final arrangements to open a hospital were completed on July 17, and two Deaconesses of the Red Cross, who had been trained in Germany, were engaged as nurses. They arrived October 10, 1888. The first directress, Anna Kypke, was in charge for two years. She was succeeded by Ida Tobschall, who later took charge of the Deaconess Home in Buffalo. The School of Nursing was organized in 1890. It is accredited by the state of Ohio. This group of Deaconess nurses pioneered in the training of midwives.[30]

The Deaconess work of Dayton, Ohio, and Indianapolis received its impulse from the Cincinnati institution. The Deaconess work in Dayton was discontinued in 1898, and in 1902 became the Miami Valley Hospital Society and Training School for Nurses.

The work of the Protestant Deaconess Hospital of Evansville, Indiana, was founded in 1892, and began as a visiting nurse service by nurse Deaconesses sent from Bethesda Hospital, Chicago, Illinois.

In June, 1893, a hospital property located on Mary, Iowa, and Edgar streets was bought, and the Sisters lately returned from Dayton, Ohio, were placed in charge. They remained but one year, and Miss Maggie Kestner of Christ Hospital was placed in temporary charge. Meanwhile, Deaconess Cora Goldsmith, who had been trained at the Lankenau Hospital, Philadelphia, was placed in charge, and remained until 1906.

[30] Golder, C., *op. cit.*, pp. 273–277.

In 1906 the Association determined to abandon the idea of training lay nurses, which had been begun during the period of Deaconess Goldsmith's administration, and staff the hospital entirely with consecrated Deaconesses. This plan was tried for a while but had to be abandoned because of the lack of vocations to the Deaconess work.[31]

The School of Nursing was organized in 1896. It is accredited by the state of Indiana. Sister Caroline Braun, R.N., has been the Superintendent of Nurses since 1906. Sister Caroline was the first Deaconess to be registered in Indiana.[32]

The Evangelical Deaconess Hospital of Lincoln, Illinois, was the outgrowth of a few patient and earnest people led by the Rev. Herm. Schmidt, and his wife, who was a former Deaconess. As in the case of Evansville, the work was begun as a visiting nurse service. There does not seem to be any record of the names of these first nurses, nor why they did not continue after the hospital was opened in 1902.

In September, 1902, Sister Magdalene came from the St. Louis Home and took charge. She was later succeeded by Sister Charlotte Boekhaus, also from St. Louis. A School of Nursing for lay nurses was organized in 1921. It is accredited by the state.[33]

Mention should be made of the very excellent work which is being done by the Evangelical Deaconesses at St. Lucas Hospital, Faribault, Minnesota. Sister Caroline Pepmeier, R.N., is the Superintendent of the School of Nursing, which is accredited.

Five other Evangelical Deaconess Hospitals deserve to be mentioned. These are: the Deaconess Hospital of

[31] "Principles of Deaconess Work," p. 92.

[32] Data gathered through questionnaire sent out by the *Journal*, January, 1929.

[33] "Principles of Deaconess Work," pp. 95–98.

Chicago; Evangelical Deaconess Hospital, Milwaukee; Evangelical Deaconess Hospital, Detroit; Evangelical Deaconess Hospital, Marshalltown, Iowa; and the Evangelical Deaconess Hospital, East St. Louis, Illinois.[34]

All of these hospitals conduct schools of nursing. All of the schools are accredited in their respective states. In most instances the members of the several school faculties are members of the state and National League of Nursing Education.

In addition to the nursing work of the Evangelical Deaconesses just described is that of the Evangelical Deaconess Society in America. Bishop Samuel P. Spreng, D.D., is the President of the Society.

These Deaconesses have under their auspices, four general hospitals. These four are located in Chicago, Illinois; Monroe, Wisconsin; Freeport, Illinois; and Waterloo, Iowa.

All of these hospitals with the exception of the one at Monroe, Wisconsin, conduct schools of nursing which are state accredited. The hospital in Monroe is known as a "small town hospital" and is an experiment to show how good hospital care may be brought to the small town community.

All of the Deaconesses in charge of these hospitals are registered nurses.[35]

The Mennonite Deaconesses

AN important group of Deaconesses of the Mennonite Church was founded by the Rev. D. Goerz in 1907, at Newton, Kansas. They are nurses and are organized on the Kaiserswerth basis. They own and operate the Bethel Deaconess Hospital, Newton, Kansas, and a hospital in Mountain Lake, Minnesota. They also have two homes for the aged and infirm.

SISTER CATHERINE VOTH, R.N.

The Bethel Deaconess Hospital was opened June 11, 1908, with three Deaconesses—Sister Catherine, Sister Freida, and Sister Ida. The hospital conducts an accredited school of nursing which was organized in 1908. The only students admitted are those who apply for some form of home or foreign mission service or for Deaconess work.[36]

The first superintendent of nurses of the Bethel Deaconess Hospital was Sister Catherine Voth. Probably no one Deaconess has made greater contribution to the professional advancement of nursing than she. A great believer in the axiom that "charity begins at home," she devoted a great deal of her life to the advancement of nursing in Kansas.

[34] "Principles of Deaconess Work," pp. 100–112.

[35] Spreng, Bishop Samuel P., "Hospital Development in the Evangelical Church," Report of the American Protestant Hospital Association, 1928, pp. 96–100.

[36] Letter from Sister Freida, R.N., to Mary Roberts, R.N., Ed. *A. J. N.*, March 6, 1929.

To write the history of the Bethel Deaconess Hospital or of the Kansas State Nurses' Association is to write a biography of Sister Catherine for the three are inseparable.

When the first probation sisters were admitted as pupil nurses in the autumn of 1908, Sister Catherine outlined their course of study, became their first teacher, supervisor, and general leader in the nursing profession. . . . As the institution faced new problems, she patiently set herself to help solve them and blazed the trail in every phase of the work. . . . During those early years she was operating room supervisor, superintendent of nurses, laboratory and x-ray technician, teacher of the Training School, and friend and helper of every patient in the house.[37]

And in addition to all of these duties there was the very important one of the development of her spiritual life. Yet withal, she had time and interest to devote to the development of her profession outside of her hospital and her Community.

Early in her professional career Sister Catherine became deeply interested in the problems of the nursing profession in general, and especially in Kansas, and was one of the founders of the Kansas State Nurses' Association in 1912. She gladly and willingly gave her help and coöperation to all movements toward better standards for the training schools and hospitals throughout the state. She was President of the Kansas State Nurses' Association from 1916–1919, and in 1924 she was unanimously elected Honorary President. Since the organization of the Association she was a member of the Board of Directors and was twice honored by being chosen official delegate to the American Nurses' Association.

Sister Catherine's last public appearance was made as an official delegate to the Twenty-fifth Convention, American Nurses' Association, Legislative Section, Wednesday, May 19, 1926, at which time she outlined plans held by the Kansas Board of Nurse Examiners for the development of pre-nursing courses: "This would," she said, "eliminate much of the teaching now done in the training school and prepare our students better to enter upon the great work of nursing. But the ultimate of all this finally is to keep alive that which I think is the spirit of this great organization, the American Nurses' Association, 'the spirit of nursing!'" [38]

In 1915 Sister Catherine was appointed by Governor Capper as a member of the State Board of Kansas for the Examination and Registration of Nurses, she was reappointed in 1919, and at the time of her death served as chairman of the Board.[39]

Sister Catherine died August 4, 1926. The last act of her life was to write a letter to her comrades, "The Nurses of Kansas." The letter dated August 2 reads:

Dear Friends:

As I am facing an operation and the outcome looks doubtful, I feel as though I had reached a definite turning point in my professional career.

My love for the great work of nursing and my respect for my co-workers of the K. S. N. A., prompt me to send you a few words of encouragement to "carry on" the good work.

Support the officers of the K. S. N. A., work toward higher standards of establishing a school of nursing in Kansas University, or in some other school in the state, with the ultimate of better care for the sick of all classes of people. Let love of God and kindness to humanity prompt your efforts and you will be a blessing to others and be blessed yourself. Thank you for all love and courtesy you have shown me.

Lovingly yours,
SISTER CATHERINE.

A scholarship fund has been established by the nurses of the state in memory of Sister Catherine.[40]

All of the Mennonite Deaconesses are trained nurses. The first Sisters were trained at the Evangelical Deaconess Home and Hospital, St. Louis, the others in their own hospital at

[37] Bull. Kansas State Nurses' Association. First Quarter, Vol. 1, p. 9.

[38] *Ibid.*, p. 8.

[39] *Ibid.*, p. 10.

[40] *Ibid.*, p. 10.

Newton, Kansas. All are registered nurses. Sister Ida Epp was one of the first Deaconesses registered in Kansas. Sister Maria Dora Richert, and Sister Lena Mae Smith are members of the League of Nursing Education.

The Mennonite Deaconesses of Beatrice, Nebraska, are likewise making a fine contribution to nursing. In their hospital they have an accredited school of nursing. All of the Deaconesses in charge are registered nurses. Sister Magdalene Wiebe, R.N., Superintendent of Nurses, and Sister Elizabeth Wiebe, R.N., are members of the League of Nursing Education. All of the Deaconesses are members of the Nebraska State Nurses' Association and of the State League of Nursing Education. One of the Sisters was a member of the Relief Fund Committee for 1927.

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A Small School Presents Its Points

IRMA LAW, R.N.

THE Northeast Missouri State Teachers' College School of Nursing was established at Kirksville, Missouri, in 1923. Kirksville, a town of 7,000 inhabitants, is situated in an agricultural district about two hundred miles from any large center of population. In the mind of John R. Kirk, at that time the education of teachers, it was hoped to interest the students in the field of school nursing.

Teaching headquarters are located in the Kirk Auditorium at the State Teachers' College with office, laboratories, lecture and demonstration rooms. Practical experience is arranged for the students with the

NURSES' HOME, PROVIDED BY GRIM-SMITH HOSPITAL AND CLINIC

President of the College, there were two reasons, based on community needs, for establishing the school. One was the need of skilled care of the sick of the town and community. As Kirksville is quite remote from St. Louis or Kansas City, considerable time was lost when nurses were called from these points. The second reason was the need for school nurses. By including courses in Hygiene and Public Health in the curriculum of an institution whose primary purpose is

Grim-Smith Hospital and Clinic, at Kirksville and, through affiliation with Washington University School of Nursing, at the St. Louis Children's, St. Louis Maternity, and Barnes hospitals in St. Louis.

Entrance requirements include graduation from an accredited high school with evidence of standing in the upper third of the class; a physical examination by the health advisor of the college who is also a member of the staff of the Grim-Smith Hospital; a

TENNIS AT STATE TEACHERS' COLLEGE SCHOOL OF NURSING

personal interview with the superintendent of nurses at the Grim-Smith Hospital. Many of the students are chosen from the young women enrolled in the college who have covered many of the subjects related to nursing. There is always a waiting list of those who wish to enter.

The course is divided into quarter-year periods and follows, in general, the course outlined by the League of Nursing Education in the Curriculum. The first quarter of the first year, the students carry ten hours of college work. Four more quarter periods are completed within the first two years, of five college hours each. The thirty semester hours of college work received during the course in nursing may be applied toward a degree of Bachelor of Science in Education, if the student wishes to continue.

The work is arranged to correlate as nearly as possible the theory in the college with practice in the hospital, and all work is completed at the college before the third year, when the students spend eight months in St. Louis to cover their affiliation with Washington University.

Students live in the nurses' residence provided by the Grim-Smith Hospital during the entire course except the eight months spent in St. Louis. The school-of-nursing students are eligible to take part in all athletics for women. Last year, in the intra-mural tournament, the nursing school played in the semi-finals and in the tennis tournament won the championship. The school is represented on the College Student Council and has a place in all social activities.

Diplomas in nursing are granted at the regular commencement on completion of the three-year course. There are twenty-six students enrolled this year.[1] Thirty-one have graduated. This school fills a community need and makes the most of its opportunities to give the student a practical basic course in a superior manner.

Announcement

THE Hospital Library Committee of the American Hospital Association announces that, effective September 17, Miss Charlotte Janes Garrison has been appointed Director of the Hospital Library and Service Bureau. Miss Garrison has long been prominent in the hospital field. She is a graduate nurse and has a fine background of successful hospital administrative experience. She is particularly well equipped to take over the direction of the Hospital Library and Service Bureau.—From the Bulletin of the American Hospital Association, October, 1929.

[1] Written in June, 1929.—Ed.

Eminent Teachers

Minna Schultz, R.N., M.A.

MISS SCHULTZ was nominated for a place in the Eminent Instructors' series by the Students' Work Committee of the Minnesota University School of Nursing.

MINNA SCHULTZ, R.N.

In other words, when tried by a "jury of her peers," she decidedly was not wanting.

Miss Schultz is a charter member of the Powell Chapter of Alpha Tau Delta Fraternity which was established at Minnesota in 1926. She has demonstrated true gifts of leadership in other ways and it is not surprising that a young woman who has been a Scout leader for many years is popular with her students.

Miss Schultz's popularity, happily for nursing, is based on sound knowledge as well as on energy and personal charm. A native of Minnesota, she was among the first nurses to secure the Bachelor of Science degree in Nursing Education from the University of Minnesota. After serving as an assistant instructor at the University of Iowa, she secured her Master's degree from Teachers College, Columbia University, in 1926. Since that time she has been an Instructor in Principles and Practice of Nursing at her Alma Mater and has been attached to the Northern Pacific Hospital, one of the institutions participating in the University School.

Editorials

"*New Occasions Teach New Duties*"

THREE appointments of unusual interest are announced in this issue. They are of interest because of the importance of the institutions to be served. What particularly concerns us, however, is the fact that they indicate new, significant, and spacious trends of thought on the part of hospital administrators.

Miss Baker's appointment as the Dean of the Duke University School of Nursing, a year and a half in advance of the time of actually taking office, indicates that careful plans are being made well in advance of the admission of the first students. Time is allowed for the discussion and development of important policies. Plans, equipment, furnishings, all will have the benefit of a nurse's knowledge of the practical situation in caring for patients and teaching nurses. It requires little imagination to visualize the school at Duke, housed in a gracious setting in lovely North Carolina and supported by an adequate endowment, becoming a Mecca for the fine flower of Southern womanhood seeking self-expression through the social service we call nursing.

The position of Ethel Johns, announced on page 1327, is absolutely unique. Work at the New York Hospital goes steadily on while the imposing new Medical Center which it will one day occupy rises on the bank of the East River. Miss Johns' task is many sided. Characteristically she began her work with an analysis of patients' needs. Plans, ratios, costs and nursing equipment all hinge on that. The educational possibilities of an institution sponsored by the New York Hospital and the Cornell Medical School, when actuated by such broad visioned policies, are tremendous.

The third appointment, that of Marian Rottman, to the newly created post of director of nursing in all the twenty-eight institutions operated by the City of New York, is in line with modern business methods. It is, however, something more than an efficiency measure although studies of costs, of ratios of nurses to patients, and of seasonal variations undoubtedly play an important part in the planning. The educational possibilities of such a centralization of nursing services are almost staggering in their immensity. Every type of nursing is available for teaching purposes. These, coupled with broad gauge vision and substantial thinking, will doubtless lead to rising and uniform standards of nursing care of patients and to a new pattern of centralization of educational programs with or without university affiliation.

Carefully chosen for their special preparation for these important tasks, these women "greet the unseen with a cheer" for they have not only preparation for large tasks, they have also fortitude, courage, and a burning zeal for the advancement of nurses and their service.

The Red Cross Roll Call

ARE you a Red Cross Nurse? Do you belong to the American Red Cross? These two questions do

not mean the same thing. Membership in the Nursing Service is based solely on professional qualifications and requires no initiation fee. Enrollment goes on the year around. It should be coveted by every nurse. Membership in the American Red Cross is open to every citizen who pays one dollar or more for the privilege. Membership in the Nursing Service, therefore, does *not* confer membership in the Red Cross itself. Between Armistice Day and Thanksgiving, we shall all have an opportunity to respond to the Roll Call by joining the American Red Cross, for cities, towns and villages throughout the country are busily preparing for this important annual event. Those who are eligible for enrollment in the nursing service and have not yet completed their applications would do very well to confer with their local committees and set about securing the coveted enrollment and the distinguishing pin that indicates a readiness to serve when disaster strikes. This, we repeat, is something quite apart from the Roll Call.

The Red Cross is almost continuously engaged, somewhere, in disaster relief. There are generally two major medical problems in large disasters. These are: first, medical, nursing and hospital care for the sick and injured; second, public health supervision of the area and the prevention of illness among disaster sufferers. It is because of this all-inclusive medical program that the enrollment of the nursing service must be as widely representative as possible. The Red Cross must be constantly in a position to call, in every section of the country, upon nurses of all types of preparation and experience for emergency service. Hardly a week goes by, in this enormous land, that the Red Cross does not respond to calls for help with disaster, storm or fire or flood. Where the Red Cross flag flies, nurses must be found.

The nursing service has another responsibility also. It is that of providing a reserve for the Army and Navy Nurse Corps. This is provided primarily for the ultimate disaster—war. In actual practice, however, the nursing service coöperates at all times with the government nursing services and reminds nurses at intervals of the great importance of maintaining these services at maximum quotas. Army, Navy, Veterans' Bureau, Public Health, each has a finely organized service, with its own particular attractions and opportunities for advancement. At just this stage in the economic development of nursing, the opportunities in government service should prove exceedingly attractive to those who appreciate the value of a stable income.

November is a month when nurses everywhere may show their devotion to the "Greatest Mother in the World" by answering the Roll Call and, if not already enrolled in the nursing service, by setting in motion the machinery for securing enrollment and the emblem of the Red Cross Nurse, the wreath-encircled Red Cross pin.

Department of Nursing Education

EDITED FOR THE NATIONAL LEAGUE OF NURSING EDUCATION BY NINA D. GAGE, M.A., R.N.

The Responsibility of the Community for Nursing and Nursing Education[1]

ANNIE W. GOODRICH, R.N.

IN requesting the substitution in the title of this discussion of the word "Community" for "Boards of Managers," as originally suggested, I am aware that I have enlarged to a perilous degree the scope of the subject—perilous only however from the standpoint of scope. There can be no question of the right of the community, that all-inclusive social unit to which we individually belong, to information, as complete as possible and given as frequently as required, upon any subject of mutual concern. The peril lies in the failure to release such information.

We are fortunate in having for discussion an activity, the community usefulness of which is not open to debate. The yearly governmental appropriations, federal, state, county, and municipal, and the constant private demand for such service bear witness to this fact.

Again it is hardly necessary, certainly to such an audience as this, to enumerate the various branches through which nursing now expresses herself, preparation for which is necessitated not less by the community's demand than by the vision of the workers themselves of the wider service to be rendered.

The task imposed therefore is a discussion of present day problems of nursing and nursing education and a consideration of the means through which may be secured an at-one-ness in dealing with these problems by those concerned. In the case of nursing, those concerned, the community, fall into three divisions, the nursing profession, the medical profession and those they jointly serve. It is the function of these three groups to achieve the means whereby may be ensured the nursing service required in the curative or remedial incidence of disease and the many means now available for its prevention. Upon this all would be agreed. Upon the methods through which these desired ends may be obtained, as may easily be understood, there is a wide divergence of opinion both within and without the nursing profession.

It has been asserted that "what determined the economic organization was not national genius but social necessity." To gaze upon the march of civilization under the generalship of necessity is to witness an advance upon ever higher levels of human accomplishment, but one in which all the forces of good or evil play their

[1] Read at the biennial meeting of the New England Division of the American Nurses' Association, April, 1929.

perennial part. The evolution in nursing makes no exception to this rule. Social necessity certainly created nursing and is now forcing changes, upon which not all are agreed.

If not the complete answer, unquestionably the integration of nursing interests and activities in any given community will immeasurably increase community understanding and coöperation, overcome faulty distribution, eliminate waste due to overlapping, promote economic security, and further efficient service through a realignment of the professional preparation and function, to the end that nursing may conform through both preparation and practice to the accepted educational standards of the day.

The Status Quo

NINETEEN years ago a commissioner of education of the state of New York, discouraged to the point of indignation by the acceptance into schools of nursing of students whose general educational preparation he felt to be prohibitively low, seriously considered advising the Regents of the State of New York to drop these schools, as he found it difficult to justify their inclusion in one of the most comprehensive expressions of state machinery for educational control and direction. He, unjustly I hope, placed the burden of this responsibility upon the profession itself.

During these subsequent years the number of children graduating from high school has steadily increased—the number of girls far exceeding that of the boys, and while the number of girls entering college has not as yet reached the number of boys, the percentage of increase greatly exceeds it; also during this period the requirement of full high school by business concerns of their young women employees has become very general, one might say almost universal. Yet today the standards of admission to schools of nursing indicate no such advance.

We are fortunately able, through the findings of the Grading Committee presented in their first publication "Nurses, Patients and Pocketbooks," to obtain accurate and extensive information as to this and other conditions bearing upon the situation in nursing. It matters not so much whether these assertions apply in detail to each locality as that a picture of the whole be achieved through reliable sources.

We have gone a long way in nineteen years, quantitively speaking, in ways and means of cure and conservation, and nursing has played her part often generously and very bravely but also at the cost of both her professional reputation and her contribution to the great field which she has entered. The interesting and vastly important developments that have taken place in the fields of education and science have remained a closed book to the social group preëminently qualified to make the practical application through which these values may be realized.

I have in mind the findings in the field of education, the field of child and mental hygiene and psychology, in nutrition, in the therapies, words that cover an almost infinite variety of conditions and ways and means of dealing with them. The terms are familiar undoubtedly, but to the great majority of nurses of whom are still demanded the long hours and heavy physical output with no background of education to enable the comprehension of these terms, they are little more than words.

How comes it that this is the case?

Because a public keenly alive to the social function of the nurse has been singularly remiss in the promotion of the educational program for such function. From the founding of the Nightingale School at St. Thomas in 1860 through the first known endowment of nursing education, and the endowments, small in amount, of the first two or three schools to come into existence in this country, in 1873, nursing education has not commanded the subsidies other branches of professional and vocational education have been able to secure. Contributions there have been and of importance,—mainly taking the form of residential facilities, generally comfortable, often very attractive, and frequently included in these domiciles were some of the needed teaching facilities, but not until the gift of Mrs. H. H. Jenkins that brought into existence the first graduate department of nursing education was *nursing education*, as such, subsidized. This opened a new chapter in the history of nursing, for it immeasurably forwarded the newer and broader concepts of the undergraduate courses—concepts that the great gifts of the Rockefeller Foundation to Yale University for its School of Nursing, and of Mrs. Bolton and her family for the Western Reserve University School will make possible to put into effect. At last we see renewed the promise to the world of the contribution of the "nurse health missioner," the more needed through the developments in medical and social sciences and in such imminent danger of loss. I am constrained to quote and at length from an article that appeared recently in an English magazine *Everyman* (quoted in the April issue of the *American Journal*):

> Every man is interested in the nurse. Sooner or later she enters every man's home, or he her's. Her status therefore is of vital importance, and the whole status of nursing has declined. It has declined from the semi-religious position, first given it by Florence Nightingale, to the level of second-class employment. Thousands of people, men and women, now look upon the vocation of nursing as "infra dig." They think it suitable for a girl of inferior intelligence, one who has a kind heart but few brains, a sound physique but no marked aptitude. Nursing has become the Cinderella of women's professions.
>
> Although the economic aspect stands in the foreground, this view of the question is to the mind of the genuine nurse of only second importance. Our subject is the status—not the pay—of the nurse. Our contention is that by subtle degrees the status of the nurse has declined, and is still declining. . . . She is still the sister of mercy; she knows her job; her position is defined, and she is able to maintain it; she is above all things efficient.
>
> It is precisely here that the trouble begins. Efficiency is a good servant, but a poor master. If it becomes the goal of any high calling, that calling is degraded by its impoverished idealism. When it is believed that anyone, given discipline, knowledge and manual dexterity, can become a nurse, than we may be quite sure that the idea of what a nurse is has deteriorated. . . .
>
> We have dehumanized the most humane of professions; we have professionalized what is by nature and noblest practice a great art. Science has demanded a standard. Rightly, because there is a level below which nursing falls to Sairey Gampism. But with the assurance that besets all factual knowledge, science has thought its standard of nursing to be sufficient; it has in fact attempted to standardize human virtue, made a science of what is in truth an art, and whenever science does this the comic spirit laughs ironically. By all means let us have all the efficiency possible, but at its highest let it be recognized as mere efficiency; let it be acknowledged that real nursing begins where efficiency leaves off.

Never was there a more timely undertaking than that of the Grading Committee; never was nursing more fortunate in its representation than through the indomitable and intrepid spirit, and brilliant and scientifically developed mind in charge of the Committee's program. I refer to Dr. Burgess.

What has been occuring in the field

of nursing has been in a most masterly way collected, analyzed, and brought before the public. However anguished we who love our profession must be at these revelations of weakness and inadequacy, we can not fail to realize the timeliness of and probable efficacy of the drastic treatment accorded and which we must acknowledge the situation demanded.

If the study of nursing and nursing education in the United States (1923) revealed the failure of the apprenticeship method to prepare the nurse for present-day needs of either preventive or curative medicine, "Nurses, Patients and Pocketbooks" presents a picture of over-production and faulty distribution, while the importance of emphasis on quality rather than on quantity, in preparing women for the nursing field, is clearly set forth.

The creation and function of the Grading Committee are entirely in accord with present-day custom. The community is increasingly turning to the experts in any given field for analysis, interpretation and recommendations. The experts on their part are increasingly seeking community coöperation.

As an illustration, for instance, the *New York Times* recently presented at length, under the caption "Thousands Aid Illness-Cost Study," the five-year national survey being conducted on the cost of medical care by a notable group of experts for whom the Metropolitan Life Insurance Company is carrying on an investigation as to sickness costs through its hundreds of thousands of policyholders. It is doing this work, it is stated, through thousands of its agents and the courtesy of the insured who are keeping calendars each month which will be collected at the end of six months, etc. This presents, let us state in passing, a remarkable illustration of community coöperation, when one realizes that the Metropolitan insures one out of every four or five individuals of the population of the United States.

Wherever we turn we witness a coalesence of the social activities and in a similar manner. Rowse, an English writer, speaks of "the clash between the present ruling aim of specialization and those integrating tendencies from which the future has most to gain." Clash there may be, but the integrating tendency has a not less creative function than specialization. In this connection and as clearly illustrative of the thought I desire to present is the following excerpt from Dr. Gesell's "Infancy and Human Growth" where we have a complete picture of one aspect of social evolution:

> Every newborn infant reintroduces into the world the age-old miracle of human growth. No matter how mechanized, how artificial, the physical conditions of the home, each birth becomes the starting point for a new reckoning with the potentialities of growth and for a series of far-reaching socialized measures. In primitive days, rites and traditions prevailed and sufficed. Today, in a typical modern community the advent of the infant mobilizes an elaborate, purposeful technic, which expresses the protective foresight of the state, and the application of medical science to the preservation and promotion of life. This technic is of relatively recent date. Pediatrics is a new subdivision of medicine. The first infant welfare station was established a mere generation ago. Systematic health supervision of the infant is only in its beginnings. But in principle a revolutionary increase in socialized control has been achieved. The new attitude and the new technic in the field of infant hygiene constitute the most significant advance which has yet been made in preventive medicine.

If economic security is an essential factor in the pursuit of happiness, and it is, the community that protests and with justice at the high cost of sickness as imperilling its economic security

would do well to keep in mind the old saying, "An ounce of prevention is worth a pound of cure."

It seems strange that there should be little or no objection taken to the support of schools for the liberal arts and such great objection taken to the support of cost of schools for the useful arts, one of the most useful and least provided for being nursing—yet preparing a group universally recognized as playing a great part in the economic security of the community, for we are familiar with the Roosevelt slogan, "The greatest economic asset is the healthy citizen." However, the movement for a program of nursing education in accord with the widening scope of her function is steadily, in some sections of the country even rapidly, advancing. The most significant in its potentialities is the increasing inclusion of nursing as a subject of undergraduate and graduate study in the university.

There have not as yet been created the specialists in the various branches of nursing required as instructors or for the development of such branches. With the growing tendency to centralization of nursing education, either through creation of schools of nursing in the universities, or the bringing under unified control of schools in a given locality, there will be an increasing demand for such specialization. It is not impossible to conceive of nursing as a participant in some of the many types of investigation and branches of research which, for instance, the recently announced Institute of Human Relations at Yale will instigate here and stimulate elsewhere. Nursing at this stage of its development is quite distinctly a surface expression of life activity dealing with the immediate and obvious, but given the preparation for a more penetrating function there could be no better opportunity from certain standpoints for observation of the free play of human characteristics than the prolonged and intimate association of nursing in the home—I refer to the private duty nurse. She might contribute a widow's mite to the following suggested projects for the Institute of Human Relations at Yale:

> Juvenile delinquency is one such field, and is likely to receive early attention. The choice of the family as the first "group" is also suggestive. . . . The complex of legal and administrative institutions which bear upon the family as a unit might be studied as a whole; or the economists' researches into living standards and family earnings might be correlated with the social incidence of disease as it comes within the view of the medical or psychiatric schools—and this again with other sociological investigations. . . .—"Synthetic Humanism at Yale," William Orton in *The New Republic.*

Whether nursing can play a part in this or not, she is finding herself and through a scrutiny of which we may justly be proud, for those who have assumed the responsibility of the investigation now being carried by the Grading Committee present in a very full sense a cross-section of the community, the producers, the product and the consumers. One could well, would time permit, analyze the undertaking indicated in the light of the groups represented by the committee members. Suffice it to say that concurrently with findings and recommendations, the desired changes and developments are in various communities and in differing forms coming into effect.

What could be more encouraging, in view of the history of the struggle of the past quarter of a century, than the following recommendations of the Special Committee on Nursing in the Medical Society of the County of New York:

1. Education of the public to meet its legitimate costs in sickness.

2. Further study and report of this Society as its contribution to the solution of the economic problem discussed here.

3. That serious thought should be given to the time, probably not far in the future, when a basic, 8-hour day, 6-day week for nurses will prevail.—From the *American Journal of Nursing*, April, 1929.

The Great Objective

ADEQUATE and efficient nursing service for a given community's health and social program.

We would all agree that this implies not only the creation of the various types of workers within the profession but a program of education that would ensure a content for such function. We would all agree that a good teaching field implies a program which in every way safeguards the well-being of the patient. This demands the highest type of service, not only as expressed in nursing, but relates to all the various means which are now accepted as included in the hospital, outpatient and other units for the care of the sick.

We are all more or less familiar with the variety of workers now demanded for these particular departments. I have in mind not only the two groups that formerly almost if not entirely covered the situation, but the physiotherapists, nutritionists, dietitians, mental hygienists, occupational therapists, dentists and dental hygienists, x-ray, social service workers, statisticians, secretaries and the vast body of employees for the care of the physical structure. Here we have the problem of specialization and integration. The nursing profession must conceive itself as that section of the community preeminently charged to safeguard and perpetuate the best traditions of the profession and formulate the program whereby its advancement may be in step with social progress.

The complexity of the problems involved is staggering, but not insurmountable. The small area, geographically speaking, the small unit of population, numerically speaking, integrated not by compulsion but through mutual understanding and consent, will complete and maintain the current of human understanding.

An aeroplane view which would reveal the city of New Haven, not only through form but function, would present a remarkable picture of such integration in process—the Chamber of Commerce, the Health Department, the Community Chest, the Public Health Council, the Joint Council of Community Nursing—centralizing in administrative blocks the directing powers of activities which permeate like the circulatory system the entire community, while from that great power house, the University, there flows a constant stream of creative light.

The Teaching of Public Health Nursing at Yale

GERTRUDE E. HODGMAN, R.N.

WHEN the School of Nursing in Yale University was founded, in the fall of 1923, through a gift to the University from the Rockefeller Foundation, one of the conditions of the gift was that the graduates of this school should be prepared to enter the field of public health nursing.

Of course, there is nothing unique in the fact that the graduates of this school *may* enter directly into the field

of public health nursing. Graduates of training schools in the country have been doing this for the past twenty or more years as the best available source of workers in this field.

However, I doubt that anyone of us felt, as we began our work in public health nursing, that we were adequately prepared. We had to learn so many new things! We had to learn to adapt the hospital technic to new situations, a much slower and more difficult process than one might imagine. The present standardized and carefully taught technic of the best public health nursing associations was not developed by any one person, nor in a short period of time. We had to learn how to teach our patients and their families, and what to teach them. We had to learn to think of prevention, as well as of cure. I remember in my first district I discouraged an infant welfare society from opening an office in the district simply because I did not yet appreciate the need and possibility of infant welfare work. And yet the infant mortality in that section must have been shockingly high. (I never knew what it was, although I finally did wake up to the fact that too many babies did not survive that first summer.) It is possible to go on endlessly telling of things which most of us did not know, nor yet know we did not know.

This situation is slowly changing. Nursing schools in all parts of the country are considering the needs of the nurse in public health and in various ways are attempting to provide a better foundation for it. Many of the courses, theoretical and practical, which are offered in the Yale School, and the methods of instruction employed have been developing in the curriculum of schools all over the country.

The definite obligation of the Yale School to prepare its students for public health work has resulted in a very concentrated effort on the part of every one connected with the school to develop the material of each department, theoretical and practical, towards this purpose. Experience in public health nursing has been considered an essential qualification for appointment on the faculty of the school. Therefore, it may be of some interest here to bring together, as a whole, certain aspects of the curriculum of the Yale School of Nursing which seem to have a direct bearing upon the requirements of the public health field, and which frequently have not been considered essential to the nursing course.

Before doing this, there is one point which should be emphasized. This is, that the main objective of the school is to educate women as nurses. The object is not to prepare them for any one of the various fields in nursing, nor is it to prepare them as "administrators, supervisors, or leaders" as has often been suggested. For positions in supervision, education and administration, we expect that the graduates of this school will feel the same need for further special preparation and postgraduate work, either here or elsewhere, as graduates of other schools. The object of the school is based upon the belief that basically nursing is one thing, whether carried on in the hospital, in connection with one patient, in private duty, or in some public health activity. If the needs of the public health field seem to be emphasized, it is because of the belief that in these aspects the public health nurse is functioning more fully at the present time as a nurse, than in other phases of work.

In other words, in this field she has assumed more fully her responsibility to care for her patient as a human

being, to bring to him the resources of the community for his welfare and to coöperate with these resources, to appreciate the need and opportunity for teaching, to consider her functions as essential to the communities' social welfare and to develop her professional services in response to the needs of the community for nursing service.

Before outlining the courses and experience provided through the curriculum in theory and practice, it is of importance to mention certain factors relative to the living and working conditions and to the supervision of the students' own health. The general living conditions are exceedingly pleasant—a dormitory apart from the hospital, where breakfast and dinner are served for students not on duty. Life in the residence is as free from restricting rules and unnecessary regulations as possible, in the hope that through this freedom the student may learn to adjust her activities to her own physical and mental capacities in work and play.

The hours of required work each week are usually limited to 44 (including class and practical work). This allows for one full day off each week and two short (6-hour) days. While this schedule is low in comparison with most nursing schools, when one considers that preparation for any class period is usually from 1½ to 2 hours, there is at least an average of from 50 to 54 hours of required work each week. This is none too low to allow for normal extra-curricular activities and interests.

The health supervision of the students, which is carried on by a full-time nurse and a part-time woman physician, includes annual physical examinations, inoculations against diphtheria, typhoid fever, vaccinations. The object of this work is definitely to teach the student the value and importance of good health for herself, to accustom her to good standards in preventive practice; to develop her responsibility for the protection of others from infection when she is ill, and most of all to develop in her sound judgment concerning the handling of her own health problems. It has been said often and truly that only when an individual believes and practises the principles of health in his own life can he be considered to have a sound foundation for the teaching of health to others.

In considering the theoretical courses of the curriculum the following are listed under the general topic "Personal and Community Health." During the first four months, or preclinic term, a course is given which is called "Problems of the Individual and Society in their Relation to Health and Disease." The time allowed for this course is 25 hours of class and 15 hours for excursions (5 excursions). The catalogue description of this course says:

> An analysis of the personal and social problems of the individual in his adjustment to life, including a consideration of the modern theory and practice of case work. Social institutions in their relation to problems of the individual illustrated through activities of this community.

The first part of the course is given by a social worker (a pyschiatric worker, as it happens) and the latter by an instructor in public health nursing with one or two special lecturers. The excursions for this course include one-half day spent with a visiting nurse. At this time the students are asked to observe especially the social and economic conditions and problems in the homes they visit (rather than any technic of nursing care). Another excursion is to a Children's Community Centre, illustrative of modern methods of

providing for the dependent child. This is part of the consideration of the problem of the dependent child as it presents itself in our society. Other excursions include visits to the County Home, showing chiefly old-age dependency; to a Florence Crittenden Mission, the Civic Protective Association (a girls' protective organization) each illustrative of some important social problems.

During the clinical period (2 years) a course in the "Elements of Public Health" (25 class hours and 4 excursions) is given by the Professor of Public Health, Dr. Winslow, and an instructor in the Nursing School. This course discusses the modern public health campaign, public sanitation, control of communicable disease, and the newer movements in the public health field, such as child hygiene, industrial hygiene, anti-tuberculosis work and the like. The nurse's function in relation to these movements is discussed through a study of nursing activities and methods of organization in these various fields. The excursions include a visit to the water filtration plant, to an industry exampling industrial hazards, methods of preventive and health activities, a dairy, and to the city Department of Health.

This course is followed by one (10 lectures or classes) called "The Relation of the Nursing Profession to the Community Health Program" described as follows, and given by Dean Goodrich and Professor Taylor:

> This course traces the evolution of social thought and responsibility as expressed through increased community provision and support of the various health and welfare organizations; the creation of new and varied types of workers, such as nurses, and nutrition, social service, and psychiatric workers, with increasing demand for a preparation that will ensure scientific knowledge and methods; the development, function, and power of the professional organizations and the importance of their close interrelationship and their part in the social program.

A course entitled "Principles and Methods of Health Teaching" (20 hours lectures and classes) is given by a public health nursing instructor to present "the importance of health teaching and the methods of presenting the fundamental facts of hygiene to undergraduates and groups." This course attempts to lay the foundation for an understanding of educational methods in health work, and especially to give an appreciation of modern educational methods which will make possible the nurse's coöperation with educational groups. It reviews and reëvaluates the principles of personal hygiene, which it is presumed the students of this school have already studied during their college work, and which material has naturally become much enriched by the general scientific and professional courses of the school.

To separate these special theoretical courses in this manner, as a means of indicating the basis for public health work which is provided in this school, is however, only half telling the tale. In each division of the curriculum one might point out certain courses or parts of courses, or certain emphases laid by the instructors, which are of fundamental significance in the education of a public health worker. For instance, we should mention the lectures in the "Normal Development of Children" (5 hours) given by Dr. Gesell of the Yale Psychiatric Clinic, as a part of the pediatric course; a course (3 hours) in oral hygiene; the course in eye, ear, nose and throat nursing which emphasizes especially the aspects which the public health worker meets most frequently, and the course in orthopedics which considers the problem of normal posture, etc., as well as pathological orthopedic conditions.

The curriculum of practical experience in both content and emphasis, has been planned with the object of preparing the nurse for meeting the community rather than any individual hospital need for her services. A large proportion of any general hospital service is of a surgical nature. In the community, on the other hand, we find the greatest health problems lie in the care for the health of children, physical and mental, in mental hygiene and psychiatry, in the field of obstetrics, in the control of communicable disease, in tuberculosis, in early diagnosis and treatment of almost all types of disease. Therefore, in developing the curriculum of this school, these community needs of the nurse have been carefully evaluated. As a result the practical experience includes a definite period of experience for every student in the communicable-disease department (3 months); in a psychiatric hospital (2 months) the Butler Hospital in Providence; in a nursery school (10 days to 2 weeks) as a part of the pediatric service; and in every clinic of the dispensary (approximately 2 weeks in each clinic), and in the community visiting nurse service (2 months), as well as the more usual services of general medicine, surgery (including accident room emergency service) obstetrics and pediatrics. To pediatrics, more than 6 months out of a total of 22 clinical months are given, if all the experience in the care of babies and children is counted.

In the pediatric and obstetrical departments, mothers are given instruction in the care of their babies before discharge from the hospital. The demonstrations which accompany this instruction are patterned after the methods used by visiting nurses in the home. Students observe and assist in this instruction. In these departments a very definite routine for referring cases on discharge to outside agencies has been developed for which the nursing service, inluding the students, holds itself responsible. In other departments every effort is being made to meet the patients' needs for instruction and to discover ways of helping them make the adjustments to the handicaps of an illness situation.

One of the most important aspects of practical experience is the assignment to the various clinics of the dispensary. These assignments are considered a part of the experience in each service and are correlated with the services. For instance, the students are sent to the pediatric clinic during the experience in pediatrics; to the prenatal and gynecological clinics during the experience in the woman's service; to the tuberculosis clinics during their experience in communicable disease. Throughout the course approximately 10–12 weeks is spent in some clinic service.

The teaching personnel of the dispensary presents a very unique situation. In each of the clinics there is at least one graduate nurse who has had experience in the public health field. The nursing service of the dispensary as a whole is under the supervision of a nurse of wide experience in public health work. From a number of clinics, a limited number of visits to the home are made, as a part of a co-operative plan with the community nursing services, upon which students may accompany the clinic nurse. The plan of clinic experience and teaching personnel makes possible an educational program for the student, not only rich in clinical material and teaching opportunity, but it also serves as a direct introduction to the nursing and health problems outside the hospital walls.

During the Senior year, each student

is sent to the New Haven Visiting Nurse Association for a two months' experience in a generalized community nursing service (except for school and crippled children's service). This experience seems to us an essential one in the education of the nurse. It rounds out her technical ability through application of nursing procedures in a situation quite different from the hospital or clinic. It serves as a basis for vocational choice (a number of students having found that they liked this work very well, contrary to their expectation). Without this experience, no matter what effort has been made to give the student an appreciation and knowledge of the possibilities of educational and preventive work in nursing, she will have missed the opportunity of actually doing it in the place where it seems to be the special function of the nurse to do it and where it has been most fully developed. In no other way can she be made to appreciate vividly the situations, attitudes, problems, and educational needs of individuals and of homes, and of the community as a whole.

In connection with this experience there are lectures and classes and demonstrations amounting to approximately 26 hours. The experience and classes are planned by the director and the educational supervisor of the Visiting Nurse Association, who is also a member of the nursing school faculty. The special and general supervisors of the association assist in this program.

Up to this point we have considered chiefly the content and emphasis in the theoretical and practical courses. The picture is in no way complete without some statement of the method of study which is employed in the experience in every service and department. This method is called the case method. It is carried on through the assignment of patients for nursing care and study with the object of centering the student's attention upon the individual and the effect of the disease upon the individual rather than upon the disease itself, or upon the technic of nursing procedures. In the hospital this method is opposed to the so-called "efficiency method" of assignment by duties, as temperatures, treatments, Senior work, Junior work, and so on. It is based upon the idea that "Real Nursing begins where efficiency leaves off." (This is not a denial, however, of the need for efficiency!)

From the very beginning of their practical experience in the hospital wards, the students are required to prepare, at regular periods, narrative case studies, and "case-experience records" which focus their attention upon the nursing needs of the patient, based upon a consideration of the social and individual factors, as well as upon the medical situation.

This case method seems to us an exceedingly valuable method of nursing study. It is especially valuable in relation to the medical situations and immediate nursing needs and care, about which the nurse must know if she is to give the intelligent care which the hospital expects of her. In considering the economic and social aspects, the value of the case studies which are made in connection with the hospital work at the present time, is chiefly an academic one, since much of the information gathered is not as yet considered essential to accomplish the work usually required of the nursing service of the hospital. In public health, on the other hand, the case and family history, in which it is never possible to separate the social from the medical and nursing factors, is the necessary basis for all constructive work. For this reason the case work

in public health has a vitality and reality to the student which is lacking in hospital work.

Whether or not the hospital nurse will ever be expected to assume more responsibility for her patient, as in public health, especially in planning for his care on discharge from the hospital, which would require her to know more about him, remains to be seen. Perhaps the advent of the graduate staff nurse supplementing student service will make possible this additional responsibility and service. At least this is a real possibility. Perhaps the very effort which schools are now making to prepare their students more satisfactorily for the field of public health will in time broaden and enrich the nurse's function in all fields of her endeavors so that we may truly say, as has been said so often with little truth, "all nurses are Public Health Nurses."

Methods of Educating the Student Nurse in Field Work[1]

MARION D. KIRKCALDY, R.N.

BEFORE beginning to discuss the various methods of educating the student in field work, it is well, perhaps, to consider what type of student is best fitted for this particular work. If, after a brief period of introduction to the field, the student is permitted to work alone, but under supervision, her previous experience is of the utmost importance. Experience in obstetrics, pediatrics, and surgical nursing is essential. In addition, if the student has spent time in a social-service department, dispensary, or in the care of communicable diseases, this accumulated knowledge will prove a valuable asset in the field of public health nursing.

Methods used to educate the student in field work should aim to facilitate transition from the hospital to the field. In the hospital, the student is on familiar ground, her patients are not only grouped together, but they must comply with the rules and regulations of the hospital. Equipment of every kind is provided for the care and comfort of the patient, and should an emergency occur, advice and help are close at hand.

In the field, however, the situation is completely reversed. District homes in no way resemble hospital wards. Furthermore, these homes vary. In one it may be an easy matter to carry out nursing procedures, but to give the same care in another type of home requires ingenuity and unusual skill on the part of the nurse. Mrs. Jones as hostess in her own home is a rather different person from Mrs. Jones the hospital patient.

Adjustment to this changed situation is one of the first things the student must learn. This is not quite so difficult as it sounds. A friendly attitude, with a desire to render service, simplifies the process of adaptation. Lack of equipment presents a problem to the student, but patients can be made very comfortable with a well furnished field bag and the ability to use material found in the homes.

[1] Paper read at an institute held at the University of Washington, Seattle, June, 1929.

When emergencies do occur in the field, the student must rely on her own initiative and give whatever care or advice the occasion demands. Unless every minute counts, a telephone call to headquarters shows quite as good judgment on the part of a new student as rashly attempted, even if well meant, treatment or advice. Organizations giving field work to students should quite definitely plan to have someone capable of giving good advice at the other end of the telephone. Prompt action in securing medical or hospital care for the needy poor who are acutely ill is, in a large city, an every-day occurrence.

The hospital student is, we know, familiar with nursing procedures. Therefore, the logical thing to do by way of making the transition easy is to give her nursing to do in the homes, after first demonstrating the procedures as practised in the field. Demonstrations should be made interesting to the point of stimulating discussion. Maternity care, surgical care, special treatments and bag technic are what are commonly demonstrated in a visiting nurse organization. Emphasis should be put upon nursing care, as well as significance of uniform technic. At a later date, return demonstrations given by a student (chosen by lot) are decidedly helpful, for her fellow-students observe and criticise and perhaps resolve to do as well themselves.

Introduction to the field marks the beginning of the student's practical experience. Initiation in this phase of the work is usually done by the staff nurses and should, of course, be delegated to those who have teaching ability. This initial stage lasts two or three days and consists of observation by the student and nursing care under supervision. In this very short period, the student can only see a limited number of patients. It is possible, however, to put into practice some of the nursing procedures taught in the station demonstrations. Care may be given to several maternities, surgical cases dressed, and in one or two instances general care may be given.

For purposes of orientation the student should now begin to work alone, but only in homes with which she is familiar. This for her is a crucial period. Her attitude is a combination of enthusiasm and apprehension. Confidence is another quality she needs, and this she can only gain by encouragement and experience. Too often we may plan the experience carefully but forget the word of commendation that means so much to a young worker. At the earliest possible opportunity the staff nurse again takes the student into the field. This time, however, she will teach the student how to make prenatal calls, how to do "follow-up" work and the proper method of dismissing patients. These calls may involve little or no nursing care, but require keen observation and the ability to make decisions. A record should be kept of all the calls which the staff nurse and student make together. In this way it is an easy matter to determine whether the student is having the right amount of field instruction.

Of course, the student should make new calls by herself, but gradually. It is only by allowing her to make first contacts that she is able to evolve plans for the care of her patients. Furthermore, in order to give a student the fullest kind of experience it is better to assign to her a district and let her work under close supervision, rather than only let her make calls for another nurse. In this way she learns how to plan and think for

herself, which, after all, is the true purpose of education.

Before the student is left entirely to her own devices, a knowledge of the methods of transportation as well as of the resources in her district is indispensable. If when making a call, the student is anxious about ways and means of reaching her next patient or has no list of telephone numbers, the right approach and good nursing can hardly be expected.

Visits made by supervisor and student are one of the best methods of teaching field work, and in most instances, this is the type of instruction which is invited by the student. She is eager that someone with more experience should see her patients, as well as to learn what progress she is making in her new work. Whenever calls are made with the student, the older nurse should do everything possible to make her feel at ease. If necessary, she should help with the care of the patient. Her skill in nursing can easily be determined even though she does not give the entire care. The student should, of course, take the initiative—that is, if she is familiar with the situation. Nursing care, however, is not the only thing to be judged. Ability to teach and her attitude toward the family and their reaction may also be observed at this time. Give helpful advice to the student where it is needed; remember to praise where praise is due. Criticism should be reserved until student and staff-nurse are alone and it should be constructive.

On some occasions the supervisor should make the entire call. The following "new" call is too difficult for a student, but presents a splendid opportunity for doing a definite piece of teaching. A request was made for a wheel chair. The first obstacle found on entering the home was that the mother could not speak English. Her friendly smile, however, was a sufficient welcome, and her simultaneous exit was, we knew, a hurried call for an interpreter. Obtaining information like this is a slow process, but if people are to be helped, the virtue of patience must be practised. Little by little the problems were unfolded: an expectant mother without medical care, and Tony, a six-year old boy, who had never walked and was not quite like other boys. Lately he had been difficult to manage and was continually getting into trouble. The stove was one danger and the stairs another. If the nurses would only send a wheel chair, Tony could be tied in and all would be well.

The obvious problem was immediately settled, but the student was taught that putting a wheel chair in the home was only the beginning of the plan for this family. Medical care had to be secured for the mother; but before this question could be decided, many important factors, such as: the wishes of the patient, income, etc., were considered. Care at a prenatal clinic was the decision made and later put into effect.

The possibility of institutional care for Tony was also kept in mind and the consent of the parents was the first step to be taken. After due consideration this was granted and necessary arrangements were made whereby Tony was examined and later placed in a state institution.

What the student learned on this call was: her responsibility to the family as a whole, the various methods of solving the problems presented, and the usefulness of friendly neighbors. All this is invaluable to the student. There are many other things to teach, which can only be taught in the home. We should teach all the practical tricks of nursing which have

been acquired by experience. At the same time we can remember and show the younger nurse all the little incidental things that can be done for the patient's comfort.

Observation visits and excursions to social agencies and institutions interested in the care of the sick and the promotion of health, teach the student the various agencies which may help her in her daily work. She, in turn, can interpret their function to others. For instance, a student can talk more convincingly to a mother about the benefits derived from attendance at an infant welfare station or a prenatal clinic after she has had the opportunity of observing their work at close range.

Theory is taught by means of conferences which are held at stated but frequent intervals. Interest can be added to this program by inviting speakers from closely related agencies; for instance, tuberculosis, care of orthopedic patients and social case work can best be discussed by persons active in those particular fields.

The noonday conference which lasts about two hours, plays a vital part in the education of the student. Every day at noon the student presents to her supervisor a brief report of the preceding day's work. Comments are made on the condition of old patients and plans made for the care of new ones. Later, however, when the student has gained in experience she offers the plans for the patient while the supervisor guides and approves.

To discuss our patients, however, is not sufficient; accurate records must be kept. Records in general may be taught at one or two of the regular conferences, but the mechanical work of keeping them takes place during the noon substation hour. At first, records are difficult for the student. This is easy to understand, for in the hospital her experience in records has consisted of making notations on charts. In the field the student must be taught to make records which not only show the problem of sickness, but at the same time give a partial picture of the economic status and environment of the patient. Emphasis, and repeated emphasis, on records as an aid in furthering effective treatment for the care of the patient enables the student to grasp their significance.

In our approach to the patient we are very careful to teach the student the correct method; therefore, it seems reasonable to instruct her how to approach, by telephone, social agencies and physicians with whom she must work.

Telephoning should, if possible, be done at the noon hour. Long and awkward telephone messages are apt to antagonize busy people. This can, however, be easily avoided by a few simple directions. First the student introduces herself pleasantly as a representative of the organization to which she belongs. Facts are then presented briefly and clearly. Important data or orders received are noted on the patient's record. Telephone calls to hospitals and dispensaries must be made to the proper source. In talking to a physician, it is very much better first to ask what we can do for his patient and later to ask for the diagnosis. If he is unwilling to give this over the phone, there is usually a very good reason for his not doing so.

The last, but by no means the least of the noon-hour activities is the fact that both staff and student nurses participate. A friendly interchange of ideas gives zest and stimulus to this occasion. Another type of conference

is the case conference. The student presents a case history to the student group and they determine the action to be taken on various problems. Discussion of cases in this manner is of great advantage to the group.

While the student is gaining practical experience in the field she should, of course, become familiar with some of the literature on public health and social work. Definite assigned readings must be a part of the student program.

The rôle of the staff nurse in the education of the student must not be overlooked. To make this program workable, one staff nurse to every two students seems to be the right proportion. With this number it is possible to release the student for class work, and at the same time ensure the right kind of care for our patients.

These various methods of demonstrations, practical work alone and under supervision, contact with other agencies, and study, are the means used to educate the student in field work, the objectives of which are: an introduction to the field of public health nursing and to teach the significance of adaptation of the nurse to patients in their own environment, to teach the technic of giving skilled nursing to the sick in their homes, as well as the nurse's part in the health supervision of the whole family. Last and very important, the student nurse is shown the relation of social conditions to disease and the need of coöperation between medical, social and other neighborhood agencies.

The Year Book

THE League is working on a yearbook which we want to make a reference book, both historical and current, for information which we all want in easily accessible form. Before we can publish this, we need some facts about endowments for schools of nursing. Will any school which has such an endowment (and endowment does not mean a gift of a nurses' residence, with maintenance to be paid annually by the hospital), please send us all the facts it can, as to when the endowment was established, by whom it was contributed, and so on? With the help of each school, we shall not omit to mention anyone having an endowment; and the sooner the facts are sent in, the sooner we can publish the yearbook.

NINA D. GAGE,
Executive Secretary.

Mental Hygiene

ON Monday, May 5, 1930, at Washington, D. C., physicians, psychiatrists, educators, industrialists, social workers, public officials and many others from all over the world will gather for the First International Congress on Mental Hygiene. This Congress will sum up the achievements of twenty years in a world-wide view of mental hygiene progress.

Questions to be discussed will include the relations of mental hygiene to law, to hospitals, to social work, to industry, to community problems, dependency, delinquency, education, parenthood, training of physicians.

Mental hygiene will be discussed also in specific application to the maladjustment problems of individuals. Special attention will be given to early childhood, adolescence and college youth. Adults will not be overlooked. These discussions will be conducted from the points of view of clinical diagnosis and treatment, community organization and the administration of institutions and agencies.

A leading feature of the Congress will be an effort to formulate a series of mental hygiene "objectives" to be striven for in all countries.

Both the American Psychiatric Association and the American Association for the Study of the Feebleminded will hold their annual sessions at the same time and place.

A membership fee of $5, including the Proceedings (less than the cost) has been fixed, in order to permit general attendance of workers in all the related fields.

The League Calendar for 1930

THE contrast shown by these two pictures in methods of teaching the student nurse is only one of the vivid pictures of changes in nursing and nursing work from ancient to modern times presented in the League Calendar for 1930. Temples of healing, methods of transportation, care of mental patients, operating rooms, care of communicable diseases, public health nurses ready for their day's work, all are placed before you to see whether or not we have really made progress as we have changed from former methods. In these days of self-examination, and of testing throughout the educational world, nursing is also "taking stock" of itself. The Calendar Committee thought a few graphic representations of differences would perhaps set us thinking.

The Calendar should make an attractive Christmas gift to anyone interested in nursing. Why should we not acquaint our friends with something of our history, and show them how, in our modern methods of work, we are trying to adapt ourselves to Twentieth Century conditions? The Calendar follows the line of the League exhibit at our summer's conventions over which so many of our people did

Teaching Nurses in Olden Times

such hard work. It should be valuable to each student of the history of nursing, whether graduate or undergraduate, as a permanent addition to her library. Pictures by some of the old masters depict ancient life and the care of the sick. There is included among these old pictures a charming copy of Benozzo Gozzoli's "St. Francis Casting out Devils from Arezzo," which every art lover will want to compare with some of Gozzoli's other pictures. The modern pictures are photographs of actual ward and public health situations, sent us by several of our members. So although the Calendar was edited by the Publications Committee, it is the product of a larger number of League members.

The sale of Calendars furnishes a considerable part of the annual income of the League, as all nurses know. It enables every nurse to help toward nursing education, whether or not a member of the League, just as she helps each year toward the support of tuberculosis work by buying Christmas seals, and toward support of Red Cross work by becoming a member of the Red Cross, each Thanksgiving. Thus we all work together for a well-rounded nursing service to the country.

Teaching Nurses in Modern Times

The Calendars may be ordered from the Headquarters of the National League of Nursing Education, 370 Seventh Avenue, New York City, at $1 each, or for only 75 cents each, if ordered in lots of fifty or more sent to one address.

Department of Red Cross Nursing

DEPARTMENT EDITOR: CLARA D. NOYES, DIRECTOR NURSING SERVICE, AMERICAN RED CROSS

The Annual Membership Roll Call

NOVEMBER 11, Armistice Day, what floods of memories are revived on recalling the day, now eleven years ago, when the people of this country, beside themselves with joy and gratitude, celebrated the cessation of active hostilities. The American Red Cross recognizing the significance of the date decided to use it for opening its Annual Roll Call for members. Peace, as far as war is concerned, has continued at least for our beloved country, but unfortunately there are other types of warfare against which the Red Cross must contend. War against pestilence, war against disasters caused by fire, flood, earthquakes, wind, etc. It must not only be prepared to render aid when the need arises, but it must engage in methods for the prevention of disasters, especially pestilence. Good Red Cross chapter organization is implied. In order to accomplish this, a qualified field staff is required. A Public Health Nursing Service, Courses of Instruction in Home Hygiene and Care of the Sick, First Aid and Life-Saving, and Nutritional Classes are maintained with the end in view of helping to prevent disasters caused by disease and accident. Service to the people of the United States cannot be maintained without money. The annual memberships are essential to this end. Therefore, it is imperative that all the resources of Red Cross organization and interest should be utilized to secure as large a number of members as possible. There are nearly 50,000 Red Cross nurses in the United States. They are listed under approximately 200 Local Committees composed of Red Cross nurses. To these and to the Committees we appeal, not only for a renewal of their own membership, but for their assistance in bringing the question to the attention of their friends, families and co-workers. An appeal for help, with suggestions for organization, has been issued to our State and Local Committees. They, however, cannot secure

results without the assistance of the Red Cross nurses and nursing organizations in their territory. For this reason we include the plan in this department:

1. We hope you will call your Committee together as early as possible after the receipt of this letter and develop a nurse roll call plan.
2. Notify all the Chapters in your territory (write us for a list if you do not know them) that you are ready to help, suggesting that you be allowed to take charge of the Nurses' Roll Call, giving your campaign plans.
3. Schools of Nursing, Hospitals, Alumnae, District and State Associations, Nurses' Registries and Clubs, should be approached and each asked to appoint someone to look after the Roll Call.
4. Roll Call literature, posters, membership buttons, blanks and informational leaflets, can be secured from the nearest Chapter.
5. Nurse speakers for the institutions are most helpful. Supply them with blanks and buttons in order to enroll members at the time. Interest dies quickly, take advantage of it before it fades. The "group enrollment" applies particularly well to schools of nursing and institutions. Won't you look into it?

We have every reason to be proud of our Committees. We also have just cause to be proud of our enrolled nurses. They have always rallied to the call of the Red Cross, whether that call be issued in time of war, or in time of disaster caused by the forces of nature. We know that we can depend upon them to help us this year to increase our membership and thus place the Red Cross in a better position to fulfill the high purpose for which it was created. We never know where disaster will strike. We do know, however, that in preparedness there is strength and effectiveness.

Letters from Red Cross Nurses from Far and Near

KATHERINE I. ELLISON, an enrolled Red Cross Nurse, in a recent letter to Red Cross Headquarters, states:

I have just returned from San Juan, Porto Rico, where I attended the Commencement Exercises of the Presbyterian Hospital School of Nursing. Miss Olive Shale (a Red Cross nurse) is Superintendent of the School of Nursing. . . . She has been Chairman of the Legislative Committee and has worked very hard for their Nurses' Bill. It passed both Houses, but the Governor did not sign it. The opposition of the Medical Board was very strong. The nurses are quite crestfallen, but I told them of some of the difficulties we had in Ohio, and the years we worked before we secured a satisfactory Nurse Practice Act. Miss Gonzales is a graduate of the Presbyterian Hospital School of Nursing at San Juan, but was unable to come to the alumnae banquet so I did not meet her. The class this year was the largest they have ever graduated (16) and for the first time they had a banquet away from the hospital.

Miss Shale reached the hospital the first of last July, and has already arranged an eight-hour day for nurses, put rollers on the screens so that the nurses need no longer carry them, put the student body in white shoes, raised the number of class hours to the minimum requirement (a matter of about 200 hours), arranged a monthly instead of a yearly meeting of the alumnae, and other things that escape my memory.

Josephine E. Jacobson, from Siangtan, Hunan, China, gives us some interesting information concerning the hospital and school with which she is connected:

Siangtan Hospital has not closed its gates during the Communistic uprising, and lost little if any of its equipment and supplies. A Hospital Committee has been changed into a Hospital Board of Directors, with a new Chinese doctor who filled a vacancy. The medical work has a prospect of a good year's work. Aside from the newly appointed Chinese doctor, all hospital staff and workers are local trained, some having been in the employment of the hospital for years and through their united efforts have done their best, in the absence of the medical missionaries on the staff. . . . The Hospital Board of Directors meet once a month to discuss and approve the policy of the hospital. The hospital staff meet once a week to discuss and plan for future work and better efficiency on the part of the hospital management, to give the best possible care at the most reasonable cost to its patients. We are aiming toward an increasing percentage of self-support, and hope

that the future will bring a few endowed beds from Chinese friends to meet the need, sometimes keenly felt.

Personnel.—One foreign and one Chinese doctor; one foreign and one female (Chinese) graduate nurse; two Chinese male nurses, one serving as acting superintendent, one serving as dispenser. . . .

The Chinese nurses and helpers have been very coöperative in helping and caring for the sick and afflicted. They show a willingness to do any kind of work, no matter how disagreeable it may be. We have conducted a class a day in elementary nursing for the young boys and nurse helpers. . . . A few male nurses will still be needed, but the majority of hospitals are already employing only women nurses.

The Chinese nurses are very fine in surgical dressings and apply bandages very well. We have been encouraged by our pre-natal clinic, several prospective mothers have come to us for examination and are now under our care and supervision. The newer generation in China is anxious to learn more about the Western methods of preparing for motherhood, they like to dress their babies more simply and plainly than formerly. A simple infant layette, which was sent from home among the many valuable supplies sent out from the United States last year, was just the thing for a mother who is preparing for her baby. One took it home to copy and was pleased with the garments. . . .

The future need will be a better trained staff and workers, making the hospital a center for welfare and health instruction, for who would be better prepared for that line of work than doctors and nurses?

Caroline Eleanor Pope, a graduate of the Lutheran Hospital School of Nursing, St. Louis, Mo., now located at Bilaspur, India, while not now in active nursing work but in the evangelistic field, writes:

My knowledge of health and nursing is of great value. Although giving Bible lessons, we give health lessons as well, using for our textbook the Red Cross series of booklets that have been developed in India under the auspices of the Indian Red Cross. These have been translated into Hindu. We are also making an effort to bring better obstetrical care to women. . . .

We are interested in work among the lepers. The hospital at Bilaspur for Women and Children now has fifteen native nurses in training, and is directed by two American nurses.

and from the Hills of Kodaikanal:

Years ago lovers of beauty sent out imported trees from Australia, hence we have tall eucalyptus, even taller than those in California; there *is* the Australian blackwood, another tall tree with a dark thick foliage. The Government has sent out pines that are beautiful. I am stopping at a hill station where there is a school for missionary children, who come not only from South India, but Ceylon, Arabia and Assam. There is an observatory here and observations are made on the sun. The radio has also penetrated to this far away country, the owner of which gets Schenectady, New York and Cincinnati, Ohio. Surely with these wonderful inventions there is no need for a lack of understanding on the part of one nation for another.

Enrollments Annulled

THE enrollments of the following American Red Cross nurses have been annulled, but their appointment cards and badges have not been returned. It is to be noted that appointment cards and badges always remain the property of National Headquarters and their return is requested when enrollment is annulled: Mrs. Kenneth Earl, *née* Margaret Virginia Richardson; Mrs. Walter G. Eberle, *née* Ella Franklin Smart; Anna Efta; Florence Etta Emmons; Mrs. Vera Jane Farrell, *née* Kingery; Lucinda Jane Fast; Nell C. Fitzgibbons; Mary Ann Fitzsimon; Mary Ellen Flynn; Magdalene Freese; Nora Frances Furnas; Mrs. Wesley E. Gatewood, *née* Zulema Isabelle Parcell; Mrs. John Goeringer, *née* Eunice Hunt; Mrs. Lewis P. Hamburger, *née* Margaret Elizabeth Hobbs; Florence Alberta Hayes; Mrs. Carl B. Helgen, *née* Otelia Leonora Stumley; Mrs. Clara Olivia Herm, *née* Henderson; Mrs. Louis Herman, *née* Katharine B. McCullough, Frances May Hersey; Mrs. Clarence C. Hightower, *née* Minnie M. McEwen; Mrs. Alice Leona Hill, *née* Mikel; Teckla Cecelia Holt; Mrs. Rex J. Homeyer, *née* Venia Fowler; Mrs. Lulu Pearl Howell, *née* White; Mrs. Marie Antoinette Ingram; Mrs. Ethel Ives, *née* Shaver; Susan Catherine Jacobs; Mrs. Archabold L. Jesmore, *née* Marie L. Clauson; Bernice Elizabeth Johnson; Mrs. Samuel J. Johnson, *née* Maude E. Simpson; Nell B. Johnson; Thelma Hester Johnston; Mrs. Patrick Kelly, *née* Florence Holm; Mrs. Laura Louise Kelsven, *née* Schultz; Mrs. George D. Ketterman, *née* Ethel Marie Webb; Mrs. Mayme K. Kocivek, *née* Lzicar; Mrs. Sophronia Koontz, *née* Akery; Mrs. Frederick Howe Lamb, *née* Blanche Eugenie Lawler.

Our Contributors

The splendid article by **Robert E. Kerr, M. D.,** Executive Secretary of the New Hampshire Tuberculosis Association, is the result of a suggestion by a New Hampshire nurse. The x-ray interpretations were made for the *Journal* by Dr. J. S. Bragg, of Manchester, N. H.

Bernadette A. Mullin, R.N., is Supervisor of the Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, Baltimore.

We present this month the second section of **Nora L. Zufall's** valuable paper on Endoscopy.

Louisa D. Hickman, R.N., a private duty nurse of California, has set an example we hope other private duty nurses will follow by sharing an interesting case with *Journal* readers.

The study of "Breast Care" by **M. Cordelia Cowan, R.N., M.A.,** is completed in this issue. Nurses who are making studies of breast or other technics are urged to communicate with the Editor.

Florence J. Potts, R.N., is Director of Nursing for the Shriners' Hospitals in this country and Canada.

James I. Coddington is Secretary of the Division for the Promotion of Annuities of the Harmon Association for the Advancement of Nursing.

Carrie E. Eppley, R. N., a graduate of the Philadelphia General Hospital, is Educational Director of the Lord Lister Hospital School of Nursing of Omaha, Nebraska.

Blanche Collier is Dietitian in charge of the Diet Kitchen she describes.

There is no question in **Dr. Burgess's** "Now What Are You Doing?" that nurses have not already asked themselves and each other many times. The *Journal* will welcome any answers readers may care to forward.

Ann Doyle's historical articles are receiving high praise. The material gathered this month involved an almost incredible amount of research.

Irma Law, R.N., President of the Missouri League of Nursing Education, is Inspector of Nursing Schools in that state. Her article suggests sound procedure for many schools which are in fortunate geographic relation to state universities or similar institutions.

Our readers will welcome another inspirational paper by **Dean Goodrich** of the Yale School.

Gertrude E. Hodgman, R.N., M.A., for some years identified wholly with public health nursing and later a member of the administrative and teaching staff of the Yale School, has recently become Director of the School of Nursing of the Toledo Hospital, Toledo, Ohio. Miss Hodgman is living up to her belief that the administration of a school of nursing requires an all-round preparation.

Marion D. Kirkcaldy, R.N., Supervisor of Student Practice Sub-Station, Visiting Nurse Association of Chicago, is a graduate of City Hospital, Glasgow, Scotland, and a postgraduate of the Chicago Lying-in Hospital. She has served as field nurse, relief nurse and industrial nurse. She was the Harriet Hammond McCormick Student in the Teachers College Public Health Nursing course and returned as Supervisor. She has studied at the University of Chicago. She made a special study of cancer patients before returning to her present position. She is the author of "Visiting Nurses and Newspapers," now in its fourth printing, and of "The Use of Records in Visiting Nursing" (The *Public Health Nurse*, November, 1923).

Student Nurses' Page

The Ultimate Goal

MADELINE V. KELLEY

Peter Bent Brigham Hospital, Boston

PROBABLY, every nurse when she first receives her orders to report to the Out-Patient Department of the hospital, has a swift vision of herself bending over some broken member of the human family and applying tourniquets and bandages so efficiently that the doctor pays her the tribute of his highest praise. She lives with this vision for two or three days and it grows always more alluring.

Then comes the looked-for day and she reports to the supervisor for her assignment, only to discover that she is to spend her day in the medical service. Here her chief duties seem to be collecting cashier's slips; delivering records to the proper doctor; telephoning for missing records; less frequently, hunting up a missing patient who has strayed into surgical service; and making supplies. She is up stairs, and down again, a thousand times a day; she gets "bawled out" because records are lost, or because patients are late, or for no reason at all other than extreme weariness and vexation on the doctor's part. He *must* boil over to some one and she is handy! At the end of her day she is weary and discouraged, and feels that though she has been busy about many things she has accomplished nothing that added greatly to the sum of human happiness.

The next day is similar. Perhaps she is assigned a clinic-diabetic, cardiac, renal, or what not. If the number of patients is small, she may read a few of the histories and feel that she has some inkling of what is happening. Still she is oppressed by the thought that she is actually doing nothing which a well-trained messenger girl could not do.

This state of affairs may last for days, or even a week or more. There comes, however, a memorable day, when a new vision rises before her, or is unveiled by some doctor, older and more sympathetic than the others.

"The purpose of this clinic," he begins, "is to prevent hospitalization if possible; if not, to reduce it to a minimum. Dozens of these people who come to us regularly, with apparently very little wrong with them, would quickly become hospital cases, if they were not carefully watched. As it is they remain fairly efficient members of society, and their beds are available for the more acute cases."

Thus easily is she given the key to her work. She sees her patients not as cases but as humans. She understands why the cardiac patient who finds his work as porter too heavy is referred to Social Service and when he reports a month later that he has a new job as houseman in a hotel, spending his days polishing brass and

silver, she feels a thrill of satisfaction that she had even a small share in making life easier for at least one person.

So with fifteen-year old Mary, the nephritic school girl, whose diet and weight are being watched so carefully in the renal clinic. When she appears one day with swollen ankles, a sore throat, and feeling badly the nurse scents trouble. Questioning may bring out that the family has been forced to move, that the "new" house is old and poorly heated and Mary has had a bad cold. Then comes the question: "Must she enter the hospital, or can this be cleared up at home?" When the doctor decides that the child must be hospitalized, she realizes the seriousness of such a decision. Before, it has seemed *so* easy to say: "You ought to go into the hospital for two or three weeks."

At last comes the day when the nurse is transferred to surgical service. Here again she finds a certain routine that must be followed, but now she has learned to see every case as a problem in human economics. When the doctor decides to inject the varicose veins of a mother with two or three children, instead of sending her to be operated upon, she realizes the importance of keeping that mother active. Who shall say that the pressure bandage is not applied a little more firmly because the nurse has seen the vision?

When colored Sarah comes in with a felon on her right forefinger, it is the nurse who discovers that she is a seamstress, taking work by the hour, and attempting to support three small nephews from her earnings. It is the nurse who checks up on her rating and reports to the admitting office, so that Sarah gets free treatment for the remainder of her long period of disability.

So the nurse learns to regard the human problem in each case, and when at last she gets the coveted experience in the accident room, she discovers that the important consideration is not: "Can we send him to the house?" but rather "Can he be returned to his usual duties more quickly by hospitalization, or can he just as well go home and come in every day or so for dressing and treatment?"

Then, all too soon, the six weeks are gone, and the nurse goes back to the wards. Life seems almost dull and humdrum by contrast, treatments are boring, the routine of bed-making and serving diets is an old, old story, and even the patients are tiresome because they are relatively few in number. Yet there is a new glow about it all for the nurse who has caught the vision and meaning of the Out-Door Department. She has glimpsed the ultimate goal of all her training, returning the patient to his usual social and economic independence as quickly and efficiently as possible, and with that goal before her, even the dreariest day will yield its quota of heart-warming satisfaction.

The Indiana Journal Contest

The contest conducted by the Indiana State Nurses' Association among student nurses for the best essays on "Why Should I Subscribe to the *American Journal of Nursing?*" and "Why Should I Be a Member of my Alumnae, District, State and American Nurses' Association?" were awarded, respectively, to Florence Carr and Effie DeYoung, both of the Epworth Hospital, South Bend.

The Open Forum

The editors are not responsible for opinions expressed in this department. Letters should not exceed 250 words; anonymous letters are not considered

Play at One of the Army Hospitals

I HAVE often wondered if nurses realize what good times members of the Army Nurse Corps can have at many posts and especially what opportunity for sport they can have at such places as the Cavalry School at Fort Riley. They're out most every afternoon by 3 o'clock, galloping over a beautiful prairie, and coming in around 5, physically tired but mentally refreshed. And if one doesn't ride there is always golf. By joining the Cavalry School Club, one has free use of the golf course, tennis courts and horses, sports which would prove rather expensive in most localities. I must not forget to mention the bowling alleys, where two nights of the week are set aside for ladies.

The majority of the ladies seem to prefer riding. A ladies' riding class for both beginners and advanced students is conducted during the fall and winter months by Cavalry officers who teach the standard riding form. The polo games are a great center of interest during the spring and summer months, an average of two games per week being played, with the sidelines always crowded.

Those of us who are more the "intellectual type" find the Ladies' Book Club of great interest, meeting twice weekly to discuss the current literature. Most members belong to the Book of the Month Club, Music Club, Book Club or Dramatic Club.

If you care only for the city and crowds you will not like Fort Riley. But if you like sports, enjoy a good game of golf or the feel of the wind in your face as you ride across the prairie, then you will like the "Life o' Riley."

LOLA LAVERNE WILSON,
2nd Lieut., Army Nurse Corps.
Station Hospital, Fort Riley.

The Women's Overseas League

ONE of the most interesting organizations that has come into existence as an aftermath of the World War is that of the Women's Overseas Service League. The qualifications for membership are that a woman must have served overseas with one of the allies between the years 1914 and 1920, and have an honorable discharge. The organization is similar to but in no way connected with the American Legion. There are now fifty-four Units of the League. The members are women who served as nurses, and as nurses' aids; as canteen workers with the Y. M. C. A., Y. W. C. A., W. W. H. A., and Salvation Army and the American Red Cross, with the American Women's Hospitals, the American Committee of Devasted France and other similar organizations.

The purpose of the Women's Overseas Service League is to keep alive and develop the spirit that prompted overseas service, to maintain the ties of comradeship, to assist and further any patriotic work; to inculcate a sense of individual obligation to the community, state and nation; to work for the welfare of the Army and Navy; to assist men and women who served and were wounded or incapacitated in the World War; to foster and promote friendship between America and the Allies in the World War.

The 1930 convention is to meet in Paris in May and the national officers wish every woman who is entitled to go, to be there, Please get in touch with Miss Jessie S. Jones, Chairman, National Membership Drive, 215 West 27 Street, Cheyenne, Wyoming, who will tell you the unit to which you should belong.

J. S. J.

An Appreciation of Miss Maxwell

WE just have read in "The *Journal of Nursing*" of February (reaching us late) the sad news about Miss Ana C. Maxwell. We are exceedingly sorry to learn that she passed away.

We consider that we have lost one of the most intelectual Nurses in the world.

We have the honor of keeping the book written by her which is translated into Spanish and we use it as a text book in our training schools. For this reason we will always remember her with veneration and love.

Please let the members of the American Nurses' Association know how much we regret this happening.

Yours sincerely
MARTINA GUEVARA,
President of "The National Association of Cuba Nurses."

The Journal Party

THE suggestion of a Journal party, which was given in the April *Journal* was tried at our alumnae meeting. We had lots of fun and it was a very helpful meeting to all present. Miss Santiago had the most points so gained the subscription to the *Journal*.

OLIVE SHALE, R. N.

Presbyterian Hospital
San Juan, Porto Rico

Warnings from Florida and Texas

MEMBERS of District 13 are anxious to warn tourist nurses against coming here for the winter season. So many come here each year and are disappointed. The season is short and folks who used to keep a nurse three weeks after an operation, often are forced financially to dispense with her after three or four days.

A. C. W.

St. Petersburg.

District 4 is receiving many inquiries from nurses who wish to come south for the winter. We do not wish to be inhospitable and we regret that at the present time it is not advisable for new nurses to locate in Tampa.

CORRESPONDING SECRETARY

Tampa.

At the last meeting of District 12 it was decided unanimously by the nurses doing private duty that steps be taken to notify visiting nurses of the serious problem of unemployment for nurses here. This information may save them considerable money.

SECRETARY

Lakeland

Nurses who are contemplating coming to Houston, Texas, to work, are advised not to do so, as there is not enough work for nurses already here.

PRIVATE DUTY SECTION, DIST. 9

Houston

"Journals" Wanted

MRS. ROBERT R. MELONE, 129 Vine St., Canonsburg, Pa., will pay for the following copies of the *Journal* and for postage: 1923, November; 1924, April, December; 1925, February, September; 1926, January.

Mabel Carroll McCracken, St. Mary's Hospital, Evansville, Ind., needs and will pay for the following numbers: 1922, March; 1923, January.

Mrs. Ione Brimmer, General Hospital, Mansfield, Ohio, will pay 25 cents each for the following: 1924, May; 1926, August; 1927, February, March.

"Journals" on Hand

MABEL C. McCRACKEN, St. Mary's Hospital, Evansville, Ind., will send for the cost of mailing: 1923, June and October; 1924, January and October; 1925, July.

Miss M. A. Candon, 66 North Willow St., Montclair, N. J., has the following copies to give away (postage should be sent): 1924, March, June, July, October, November; 1925, January.

Mabel Stevens, 200 S. Chestnut St., Lansing, Mich., has copies of the Journal for 1926–1929, almost complete, which she would be glad to give away for the cost of transportation.

Mrs. Mary R. H. Brown, 461 Lisbon Ave., Buffalo, N. Y., has an almost complete file of the *Journal* to sell. Inquirers should state what they would pay for the volumes, the earlier ones being now scarce and of value.

No More Journals nor League Reports

I HAVE no available copies, longer, of Journals nor League reports. Requests are many and I have no secretary.

HELEN SCOTT HAY

Savanna, Ill.

League Reports Wanted

ADDA ELDREDGE, Bureau of Nursing Education, State Board of Health, Madison, Wis., wishes to secure copies of the League Reports for the following years: 1895, 1898 through 1908, and 1911.

League Reports on Hand

ADDA ELDREDGE, Bureau of Nursing Education, State Board of Health, Madison, Wis., has duplicate League Reports for 1896 and 1918.

Abstracts

H. O. McPheeters, M.D.: The Present Status of the Injection Treatment of Varicose Veins. (*Long Island Medical Journal*, September, 1929.)

THE injection treatment of varicose veins has attracted such wide attention in the medical profession during the past two years that today it is accepted as one of the foremost advances made by the members of our profession during that time. . . .

Normally, all the blood flows upward toward the heart in the venous system, both superficial and deep. During the course of the development of varicose veins, this flow becomes retarded and finally comes to a standstill. Later, when the condition has fully developed, the flow actually becomes reversed so that the blood flows outward from the femoral through the sapheno-femoral opening, downward toward the foot, again entering the deep system through the communicating branches of the lower leg. . . .

It is clear from the above findings how the tissues of the lower leg become congested by this continued extreme back pressure and how the tissues finally become water-logged by the serum, as a consequence of the stasis. . . . This poor circulation so lowers the vitality of the tissues that they are no longer able to survive the element of trauma. When these tissues are traumatized they rapidly break down and produce ulceration. It is thus very apparent that any treatment which may be directed toward this condition must be by means of freeing the tissues from the edema present, allowing a better oxygen supply, and clearing the tissues of the excess carbon dioxide. . . .

The cure of varicose veins by the injection treatment is based on the same principle as is the operative treatment which has been sponsored by no less authorities than Charles Mayo, Babcock, Bernstein, etc. By that I mean the surgical removal *or* obliteration of the varices. If the same results can be accomplished by the injection treatment as have been secured in the past by the operative, yet much more thoroughly in each case, with 70 times less possibility of fatality from embolus, with no danger whatsoever of postoperative pneumonia, with the chance of an infection of the operative field almost nil, and finally with no loss of time from work and with no hospitalization, then must we not have to admit that the injection treatment of varicose veins is a great step forward?

The injection treatment is based on the theory that we can develop a localized destructive action on the intima of the vein wall by the injection "within the vein lumen" of some corrosive solution. . . .

Many solutions have been suggested for use in this work. . . . Today the solutions used by the majority of men, in the order of their importance and frequency of use, are as follows: Sugar solutions or solutions of invert sugar, dextrose and glucose; sodium chloride 20 percent; sodium salicylate 20, 30 and 40 per cent; quinine and urethane solution, commonly called Genevrier's solution; the bichloride of mercury 1 per cent; and metaphen 1–500 solution. In the author's experience the calorose or invert plus cane sugar of Eli Lilly and the invertose compound which is a combination of invert sugar and sodium salicylate have been the most satisfactory of any. None of the above solutions meet all the requirements for this work in every case and there are criticisms and objections to them all. Various combinations of these seem to offer an improvement for the future.

Each man must develop his own technic for the actual injection. He must have a clear-cut idea as to the principle and theory of the treatment and then use his own judgment how best to apply that in the individual case. . . . The patient may be standing; kneeling on a chair and standing on the leg to be injected; sitting on a table with the leg merely hanging; or lying prone on a table with the legs extended on the horizontal. It is true that the technic varies somewhat according to the solution used; however, the principle remains the same in all cases. . . .

Personally, the author believes that each case must be considered separately as to the technic of the actual injection. . . . In giving the injection I much prefer to use a 21 or 22 gauge, short beveled needle. . . . I prefer some type of syringe with rings for the first two fingers and thumb in order that I

may have more accurate control of the pressure, both positive and negative, on the syringe contents. . . .

With the patient lying prone, gravity will empty the veins completely. The tourniquets are then applied about 4 inches apart, using only sufficient pressure to compress the superficial varices and not enough to cause any effect on the deep system. Sufficient blood will then remain in the segment to fill and distend one short loop. The needle is then inserted into this distended loop and the solution injected. . . . With the vein distended, the needle is left *in situ* to prevent leaking, for 2 to 5 minutes, depending on the case. After that time a small gauze sponge is applied directly over the site of the injection *as* the needle is withdrawn. This is done to prevent leakage from the needle tract and a resultant slough. The sponge is merely held in place with adhesive, strapped tightly, for 5 to 6 hours. As a rule the patient is instructed to remove the adhesive and sponge when he retires at night.

Elliott P. Joslin, M.D.: Prevention of Diabetic Deaths. (Report of Department of Public Health, Commonwealth of Massachusetts) 1929.

COMA develops because of ignorance, negligence or carelessness. Diabetics go into coma carelessly when they break their diets and overeat; they go into coma as a result of negligence when in the course of an infection, either general like measles or local like a boil, they neglect to make the proper tests to determine whether they are using enough insulin; they go into coma ignorantly, because they stop their insulin when they cease to eat for one cause or another.

A diabetic should never omit his insulin unless his urine is sugar-free. He must never forget that when he stops eating food he begins eating himself—his own body—and so still requires insulin and often very much more insulin than before. If he has an infection as a cause of his loss of appetite, he should know that an infection lowers the value of insulin and thus makes more insulin than usual a necessity.

Coma, and by diabetic coma is meant acid poisoning, is a sly fox, and will steal away a diabetic before he or his friends suspect it. Within a few hours mild symptoms such as indigestion, lack of appetite and pain in the abdomen may be followed by difficult breathing, drowsiness and unconsciousness. The only safe way, therefore, for the diabetic to protect himself against coma is to keep well and sugar-free all the time.

I try to instill into the minds of every diabetic I see that whenever he feels ill and sick, he should: (1) call his doctor, (2) go to bed, (3) take a hot drink every hour, (4) take an enema, (5) keep warm, (6) get a nurse or someone to care for him. Another good rule is to have boiled water ready for the doctor when he arrives, in case he wishes to use it.

Minor differences in the treatment of coma exist, but all agree that promptness in diagnosis is everything, and next to it comes energetic treatment at the earliest possible moment. If coma exists, the doctor must give up everything else until the patient comes out of it. (1) Insulin is usually required every half-hour in 10- to 40-unit doses or more, varying with the severity of the symptoms, and if it is given intravenously it should always be given subcutaneously at the same time. (2) Dehydration of the patient must be overcome by the subcutaneous injection of normal salt solution, and one cannot rely on fluids by mouth or rectum. (3) The heart is almost always weak and needs stimulation with caffeine sodio-benzoate, 7½ grains, and this may be given every hour if need be, for three or four doses. On account of the weakness of the heart, salt solution must be injected very slowly if given intravenously. (4) With children and usually with adults the stomach is distended, and unless evacuated prevents the subsequent retention of liquids such as water, gruels, ginger ale or the juice of two or three oranges; in other words, carbohydrates amounting to 50 grams. Therefore, gently wash out the stomach.

Sex Instruction

RETICENCE without secrecy would seem to be the desirable objective. . . . It is the mother's responsibility to know where children are and what they are doing. Especially she should know what sort of companions they habitually associate with. This does not mean a system of espionage, it does mean careful supervision on the parent's part, as little obvious as possible to the child. No amount of surveillance can guarantee a child's behavior. The best that parents can do after they have provided all possible safeguards in the way of knowledge and oversight, is to *trust* the child. An attitude of suspicion, a readiness to believe the worst, is a poor atmosphere in which to create the positive type of controlled behavior which we wish to build up.—From "Parents and the Pre-School Child," pp. 157 and 164, William E. Blatz. Publisher: Morrow & Co.

News

Note.—News items should be typed, if possible, double space, or written plainly, especially proper names. All items should be sent before the 15th of the month preceding publication

American Nurses' Association

DIGEST OF THE MINUTES OF THE MEETINGS OF THE A. N. A. BOARD OF DIRECTORS

The Board of Directors of the American Nurses' Association, meeting September 16, 17, in New York City, considered a wide variety of subjects.

The International Council of Nurses.—Reflections of the Montreal Congress of the International Council of Nurses were shown at intervals throughout the sessions, especially through the splendid reports of the Congress given by the President, Miss Clayton. The action of the Grand Council in raising the I. C. N. dues from five to eight American cents for each member annually was ratified by the Board. This action, it was explained, was taken because I. C. N. Headquarters' work has been enlarged necessarily with the constantly increasing demands made upon it as nursing expands from country to country. As a constituent member of the International Council of Nurses, the A. N. A., it was felt, had no alternative but to approve this increase in the I. C. N. dues as authorized by the Grand Council. This ratification on the part of the A. N. A. Board does not mean, however, that there is a corresponding increase in the A. N. A. dues. It does mean that this sum will be added to the budget of the National Association, thus limiting by that amount the work of the National in the interests of the states. The A. N. A. would welcome, therefore, as in previous years, contributions toward the I. C. N. dues on the part of the states, with the double advantage of furthering the work of the International, and at the same time relieving the National, which then can turn that sum into the work for the states and their component parts; it would seem an excellent investment on the part of the states. The change in the I. C. N. publication was discussed by the Board. The former *I. C. N.*, a quarterly, has given place to the *International Nursing Review*, which will appear in six issues each year, the subscription price being $2.00.

Membership Campaign.—The year 1931 will mark the thirty-fifth anniversary of the founding of the American Nurses' Association. It was voted by the Board of Directors that, in this connection, there be conducted a nation-wide membership campaign.

A. N. A. Seal.—The A. N. A. seal, the use of which hitherto has been confined largely to the Headquarters' office and to the stationery used by Board and committee groups, now is available for use in the states. The Board so voted in September with the suggestion that the name of the State Association be printed around the seal instead of that of the National organization, and that under the seal there be placed the statement that the State Association is a member of the American Nurses' Association.

Milwaukee Biennial.—It was voted by the Board that some time before the polls open at the 1930 Biennial Convention, the findings of the Common Activities Committee relative to the suitability of the cities inviting the 1932 Biennial be announced, and the person commissioned to present the invitation of each of these cities be given an opportunity to speak from the platform, and that the names of these cities be printed on the ballot in order that the delegates may record their votes thereupon.

The Board voted also that the Arrangements Committee of the Biennial be asked to provide seating space at the business sessions for the accredited delegates, designated by signs, and distinct from seating space for other nurses and visitors; and that distinctive badges be issued to accredited delegates and that they be requested to wear them in

attendance at all business sessions. There was discussion of various methods of distribution of the credential cards and badges so that all accredited delegates might be promptly registered and accounted for, but no action was taken in this matter.

Mrs. Alma H. Scott, Field Secretary of the A. N. A., was appointed by the Board to act as Transportation Chairman for the Biennial. It was felt that the whole matter of transportation could be handled to best advantage from Headquarters with the Chairman working in close coöperation with railroad representatives and with sectional transportation chairmen.

Historical Sketch.—Designating the *Historical Sketch of the American Nurses' Association* as "a text for members of the Senior classes in schools of nursing," the Board voted that the value of the Sketch for this purpose be pointed out to the schools. This leaflet is on sale at Headquarters for twenty-five cents a copy.

Institute for State Executive Secretaries.—An Institute for state executive secretaries was decided upon by the Board, this Institute to be held at Headquarters in March, 1930. It was voted that inasmuch as there is sometimes difficulty in determining who is executive secretary of a particular state, state executive secretaries must be certified to Headquarters by the states.

Alphabetical File.—The A. N. A. Board voted, as the Advisory Council had recommended in June, that the states be urged to assist in working out an alphabetical file of A. N. A. membership at National Headquarters. It was reported by the Director that first communications had been sent to the states from Headquarters, asking the states to give their opinion on the suggested forms for reporting A. N. A. membership, and that they state how many such forms would be needed for that purpose in their state.

Bordeaux School.—The report of Miss Noyes, Chairman of the American Nurses' Memorial Committee, that the $25,000 needed to build the right wing of the Florence Nightingale School of Nursing at Bordeaux, France, had been given with an over-subscription of approximately $5,000, was received by the Board with appreciation and enthusiasm. The questions were discussed of what to do with the surplus and of the transmittal of funds, but no decisions will be made until the matter has been discussed with Dr. Hamilton. It was voted by the Board that if it seemed best, Miss Noyes should be instructed to go to the School at Bordeaux and study the situation at first hand.

National Committee on Red Cross Nursing Service.—The election of members from the American Nurses' Association to the National Committee on Red Cross Nursing Service resulted in the reëlection of Jane E. Nash, Mary E. Gladwin, and Susan C. Francis. The vacancy left by the death of Anna C. Maxwell was filled by the election to her place of Mrs. Anne L. Hansen.

Accredited List.—"The List of Schools of Nursing Accredited by State Boards of Nurse Examiners" will not be revised in 1930. It was felt by the Board that a biennial revision was not necessary at this time and it was voted that the entire problem of the Accredited List be referred to the Committee to Consider the Continuation of the Work of the Grading Committee, together with the A. N. A. Publications Committee, these committees to consider not only the question of the content of the book, but the auspices under which it should be compiled and published. It was voted, further, that in the next revision of the Accredited List, the schools of nursing in Hawaii and Porto Rico be included.

Bordeaux School Campaign

Real appreciation and enthusiasm were evidenced by the Board of Directors when, at its September meeting, Clara D. Noyes, Chairman of the American Nurses' Memorial Committee, gave her report of the successful campaign for $25,000 to build the right wing of the American Nurses' Memorial Building which houses the Florence Nightingale School of Nursing at Bordeaux, France. Since the report was given, however, more contributions have been received until now there is an over-subscription of about $6,000.

CONTRIBUTIONS BY STATES TO SEPTEMBER 30

State	*Quota*	*Contributed*
Alabama	$192.40	$213.40
Arizona	55.60	71.20
Arkansas	160.00	160.00
California	2,112.00	2,108.38
Colorado	272.00	277.00
Connecticut	744.00	744.00
Delaware	60.00	60.00
District of Columbia	335.60	350.15
Florida	356.80	581.49
Freedmen's Hospital	24.00	....
Georgia	314.00	327.19
Hawaii	29.60	179.00
Idaho	33.60	....
Illinois	1,918.80	2,122.04
Indiana	490.00	544.85
Iowa	652.80	695.00
Kansas	298.00	298.00
Kentucky	223.20	527.59
Louisiana	405.20	627.77

Maine	192.80	197.00
Maryland	631.20	821.30
Massachusetts	1,623.20	1,024.60
Michigan	1,142.40	1,226.00
Minnesota	964.00	748.80
Mississippi	90.40	90.40
Missouri	987.60	1,209.00
Montana	68.40	139.25
Nebraska	319.60	342.19
Nevada	12.00	12.00
New Jersey	811.20	1,052.00
New Hampshire	157.60	168.10
New Mexico	29.20	29.20
New York	3,906.00	4,278.08
North Carolina	310.40	332.40
North Dakota	74.00	158.50
Ohio	1,708.40	1,327.50
Oklahoma	177.20	191.16
Oregon	263.60	60.00
Pennsylvania	2,989.20	1,914.46
Porto Rico	11.60	11.60
Rhode Island	263.20	275.70
South Carolina	114.80	84.40
South Dakota	57.20	57.20
Tennessee	322.00	205.00
Texas	778.80	928.60
Utah	79.60	79.60
Vermont	102.40	107.25
Virginia	284.00	337.50
Washington	455.20	455.20
West Virginia	162.00	162.00
Wisconsin	466.40	466.40
Wyoming	16.80	16.80
Special contributions		540.00
Contributions outside of State Associations.		2,185.00
Total		$31,121.25

Nurses' Relief Fund

REPORT FOR MONTH ENDING SEPTEMBER 30, 1929

Receipts

Interest received on investments	$277.50
Interest received on bank balance	6.91

Contributions

Arkansas: District 1, $7; District 3, $10; District 4, $10; District 5, $50	77.00
California: State Nurses' Assn.	24.00
Florida: District 1, $12; District 6, $5; District 9, $11	28.00
Illinois: District 1, $13; Washington Blvd. Hospital Al. Assn., $10; individual contributions, $94; District 3, $10; District 5, $76; District 8, $1; District 13, $110	314.00
Iowa: District 7, $78; District 8, $42	120.00
Kansas: District 1, Stormont Al. Assn.	42.00
Massachusetts: Essex County Branch	10.00
Minnesota: District 3, St. Cloud, $1; District 4, Ancker Hospital Al. Assn., $8; Ancker Hospital patients, $11; individual members, $3	23.00
Missouri: District 1 (St. Joseph), St. Joseph's Hospital Al. Assn., $85; District 3, (St. Louis), individual contributions, $1	86.00
New Jersey: District 1, Mountainside Hospital Al. Assn.	102.00
New York: District 2, Rochester Gen'l Hospital Al. Assn., $100; Genesee Hospital Al. Assn., $33; individual members, $5; District 4, $170; individual contributions, $9; District 11, Student Nurses, Benedictine Hospital, Kingston, $10; Benedictine Hospital Al. Assn., $55; Student Nurses, St. Luke's Hospital, Kingston, $10; Student Nurses, City Hospital, $7; District 13, $82.94; individual contribution, $2; District 14, Brooklyn City Hospital Al. Assn., $25	508.94
Tennessee: Middle Tennessee District Assn., $12; Chattanooga, $35	47.00
Texas: District 1, $5; District 16, $2	7.00
Wisconsin: District 3, $70; St. Mary's Hospital Al. Assn., $18; Districts 4–5 individual contributions, $2; District 6, Theda Clark Hospital Al. Assn., $22; District 7, $131; District 9, St. Mary's Hospital Al. Assn., $10; District 10, individual contributions, $2; District 11, St. Joseph's Al. Assn., $10; individual contributions, $5; District 12, individual contributions, $3	273.00
Total receipts	$1,946.35

Disbursements

Benefits paid (191 applicants)	$2,697.00
Salaries	254.16
	$2,951.16
Excess of expenditures over income for month ending September 30, 1929	$1,004.81

All contributions to the Nurses' Relief Fund should be made payable to the *Nurses' Relief Fund* and sent either to the person who collects your dues or to the local Relief Fund chairman. The method for collection of contributions varies in the states. Your district president or treasurer can tell you to whom your checks should be sent. For application blanks for beneficiaries, apply to your own alumnae or district association, or to your state chairman. For leaflets and other information, address the state chairman or the Director of the American Nurses' Association Headquarters, 370 Seventh Avenue, New York.

Isabel Hampton Robb Memorial Fund

There is no report, as no contributions were received up to October 11.

The McIsaac Loan Fund

REPORT TO OCTOBER 11, 1929

August 12, Balance		$244.32
Contributions		
Milwaukee Branch of Illinois Training School Alumnae Assn.		10.00
Total		$254.32
Disbursements		
Bank charge	$1.00	
One loan made	200.00	201.00
October 11, Balance		$53.32

MARY M. RIDDLE, *Treasurer.*

Contributions to the Robb Scholarship Fund or the McIsaac Loan Fund should be sent to the Treasurer, Mary M. Riddle, Care *American Journal of Nursing*, 370 Seventh Avenue, New York. Checks should be made separately for the two funds.

Army Nurse Corps

During the month of September, 1929, orders were issued for the transfer of members of the Army Nurse Corps to the stations indicated: to Army and Navy General Hospital, Hot Springs, Ark., 2nd Lieuts. Sarah Hawkins, S. Myrtle Heale; to Fort Banks, Mass., 2nd Lieut. Alice M. McCauley; to William Beaumont General Hospital, El Paso, Texas, 2nd Lieuts. Johanna Gorman, Elizabeth G. Mahoney; to Letterman General Hospital, San Francisco, 2nd Lieut. Lola L. Wilson; to Station Hospital, Fort McPherson, Ga., 2nd Lieut. Katherine I. Herron; to Station Hospital, Fort Riley, Kans., 2nd Lieut. Bertha Appleman; to Station Hospital, Fort Sam Houston, Texas, 2nd Lieut. Nancie Allen; to Station Hospital, Fort Sill, Okla., 2nd Lieut. Mary C. Strawinski; to Station Hospital, Fort Totten, N. Y., 2nd Lieut. Anne E. Hynds; to Walter Reed General Hospital, Washington, D. C., 1st Lieuts. Lyda M. Keener, Rae D. Landy, 2nd Lieuts. Nelle Sullivan, Helen A. Taggart, Mary E. O'Donnell, Alle Salzman.

Eleven have been admitted to the corps as 2nd Lieuts.

The following named, previously reported separated from the Corps, have been reassigned: 2nd Lieuts. Belva A. Towery, Edna M. Livingston, to Letterman General Hospital, San Francisco.

The following named are under orders for separation from the Corps; Edna G. Strobel, Margaret E. Thompson, Barbara R. Musch, Bess Stringfellow, Esther M. Finch, Rowena M. Boone, Sue Bigler.

SAYRES L. MILLIKEN,
Captain, Army Nurse Corps,
Assistant Superintendent.

Navy Nurse Corps

During the month of September, seven nurses have been appointed and assigned to duty.

The following transfers were made: to Canacao, P. I., Mary F. Bosco; to Chelsea, Mass., Rose K. Conley; to Guam, M. I., Florence A. Linderman, Ida E. Brooks; to Guantanamo Bay, Cuba, Julia Lennon; to Mare Island, Calif., Helen C. Noel, Florence M. Field; to Newport, R. I., Laura M. Gemberling; to New London, Conn., Dispensary, Submarine Base, Mary T. O'Connell; to Pearl Harbor, T. H., Mary W. White; to Portsmouth, Va., Pharmacist's Mates' School, Joanna Ferris; to St. Thomas, V. I., Elizabeth H. Beall; to Washington, D. C., Nora A. Reardon, Anna G. Keating.

The following nurses have been separated from the Service: Margaret L. O'Halloran, Elizabeth Zombro, Okie G. Kennedy, Ethelyn S. Everman, Margaret M. Redmond.

J. BEATRICE BOWMAN,
Supt., Navy Nurse Corps.

U. S. Public Health Nursing Service

New Assignments: Eleven.

Transfers: To Stapleton, N. Y., May Bennett, Asst. Chief Nurse; to Detroit, Mich., Marjorie Walton, Chief Nurse; to Ellis Island, N. Y., Margaret B. Davis, Florence Donoghue, Pauline Wells; to Memphis, Tenn., Ellen Morris; to Norfolk, Va., Ruth C. Dalton; to New Orleans, La., Bernice Rogers, Anna Dudte, Orpha Dudte.

Reinstatements: Ethel McCay, Alice Elliott, Alma Peterson Baker, Margaret W. Ramsey.

LUCY MINNIGERODE,
Supt. of Nurses, U. S. P. H. S.

United States Veterans' Bureau

REPORT OF NURSING SERVICE

Employment in the nursing service of the Bureau offers, among many other advantages, the certainty of progress. Announcement was recently made of a plan now being worked out, with the approval of the Director, to render the educational and inspirational resources of the Bureau most serviceable to the nursing personnel. The newly created formal program of Staff Education in Psychiatric Nursing to be initiated in all the hospitals of the U. S. Veterans' Bureau—special postgraduate courses to be made available for the nurses in the service—has received much favorable comment.

During the month of September, 1929, orders were issued for transfer of the following named nurses: To U. S. V. H., Chillicothe, Ohio, Helen Skeels; to Aspinwall, Pa., Mary Galbally; to Fort Snelling, Ellen Swanson;

to Palo Alto, Calif., Estelle Yetka; to Fargo, N. Dak., Kathryn Simons; to Outwood, Ky., Gertrude Hasenjaeger; to N. Little Rock, Ark., Anna Kelly; to Kansas City, Mo., Norma Spaeth, Mollie Nihart; to Bronx, N. Y., Nora Murphy; to Regional Office, New York, Mary W. Gately; to Augusta, Ga., Jessie Durand; to Tucson, Ariz., Dana Huddleston; to Castle Point, N. Y., Mary Brogan, Clara Espey; to North Chicago, Ill, Winifred Ephlin; to Boise, Idaho, Matilda Fullerton; to Jefferson Barracks, Mo., Dollie Smothers, Senith Smith; to Whipple, Ariz., Ellen Robinson, Etta M. Mason; to Lake City, Fla., Bess Ross; to Edward Hines, Jr., Hospital, Hines, Ill., Zella Bradford; to Ft. Bayard, N. M., Rose Behan; to Muskogee, Okla., Clara Schoenfelder.

The following were reinstated: Katherine B. Keene, Edith F. Nichols, Lisetta Korb, Inez Spurgeon, Mabel T. Morse, Margaret Griffith, Elizabeth Lake.

Twenty-nine new assignments were made and the following nurses have been separated from the service: Helen A. Booth, Mary G. Brown, Anna Bruce, Anna P. Casey, Janie B. Clark, Fannie B. Cline, Alice J. Cumming, Estelle G. Gillis, Fannie Graham, Lucille Granay, Lulu G. Hatfield, Carolyn S. Hammock, Mae H. Hammer, Frances E. Hogg, Ethel L. Judy, Theresa A. Just, Katherine B. Keene, Winona B. L. Kutzleb, Minnie G. Latimer, Zona M. Leach, Eunice J. Long, Thankful M. Macy, Greta M. Malone, Heldred McKenney, Frances C. McQuade, Estella M. McManes, Dorothy M. Morrow, Emma V. McDowell, Clara L. Myre, Blanche Newson, Grace M. Rowe, Myrtle Ricketts, Mabel Schuckman, Gladys L. Smith, Hildegard A. Soldier, Rheva A. Speaks, Ruth I. Skarpness, Kathryn I. Stone, Margaret M. Taylor, Edna G. Thompson, Margaret A. Tracy, Winnie D. Travis, Laura Washburn, Hannah Walquist, Anna E. West, Mary Woods, Elizabeth Young.

MARY A. HICKEY,
Supt. of Nurses, U. S. V. B.

United States Civil Service Examinations

The UNITED STATES CIVIL SERVICE COMMISSION announces open competitive examinations for the positions of chief nurse and head nurse in the Indian Service, graduate nurse, graduate nurse, visiting duty, and graduate nurse, junior grade, in various services. For details, apply to the U. S. Civil Service Commission, Washington, D. C.

Institutes and Special Courses

Texas: An Institute will be held at the Nurses' Home of Seton Infirmary, Austin, November 6–9, by the Texas State League of Nursing Education. Mrs. Alma Scott, representing the American Nurses' Association, will discuss matters of national interest. Dr. J. L. Henderson, Professor in Education at the University of Texas, will give a series of lectures on "The Foundation Principles of Teaching," and Dr. F. A. C. Perrin, Professor in Psychology, will discuss "Teaching Psychology" and "The Short-type Question." The matter of a summer course in the Texas University will be discussed.

State Boards of Examiners

Alabama: The NURSES' BOARD OF EXAMINATION AND REGISTRATION OF ALABAMA will hold examinations in Birmingham on November 5–6; in Montgomery, on November 6–7; in Mobile, November 8–9. Applications must be filed with the Secretary, Linna H. Denny, 1320 North 25 St., Birmingham.

Delaware: The DELAWARE STATE BOARD OF EXAMINERS FOR REGISTRATION OF NURSES will hold the next examination at the Homeopathic Hospital, Wilmington, on Monday, December 2, at 9 a.m. All applications must be in the hands of the Secretary, Mary A. Moran, 1313 Clayton St., Wilmington, not later than November 23.

Kansas: The KANSAS STATE BOARD FOR EXAMINATION AND REGISTRATION OF NURSES will hold the next examination in Emporia, December 10 and 11; headquarters, Broadview Hotel. Cora A. Miller, Secretary-treasurer, Newman Memorial County Hospital, Emporia.

Oklahoma: The OKLAHOMA STATE BOARD OF NURSE EXAMINERS will hold examinations, December 4 and 5, at the State Capitol in Oklahoma City. Send applications to the Secretary, Mrs. Candice M. Lee, R. 4, Oklahoma City.

Vermont: The VERMONT BOARD OF REGISTRATION OF NURSES will hold a public examination for registration at the State House, Montpelier, November 7 and 8. Hattie E. Douglas, Secretary, West Rutland.

Wisconsin: The next WISCONSIN STATE BOARD EXAMINATION will be held on December 3, 4, 5 and 6, in the City Hall, Milwaukee, and the Court House, Ashland. Adda Eldredge, Director, Bureau of Nursing Education.

Wyoming: The WYOMING STATE BOARD OF NURSE EXAMINERS will hold examination and registration for nurses in Cheyenne, December 2–3. Applications to be filed with the Secretary not later than November 15. Mrs. H. C. Olsen, Secretary, Cheyenne.

State Associations

District of Columbia: The present Secretary of the DISTRICT OF COLUMBIA LEAGUE OF NURSING EDUCATION is Elizabeth Dempsey, succeeding Miss Smithson, who is no longer in the District of Columbia.

Maine: The next annual meeting of the MAINE STATE NURSES' ASSOCIATION is to be held January 3 and 4, 1930, at the Bangor House, Bangor, Maine.

Massachusetts: "Staff Education" was the subject of the League of Nursing Education section of the MASSACHUSETTS STATE NURSES' ASSOCIATION, at its meeting in Northampton on October 4. Clare Dennison explained that staff education, which is "studying on and off the job," is needed to bring one's earlier education up to date and to give confidence in one's methods. Choice of subjects for study must be determined by individual needs, and it is comparatively easy to find and use them in nearby colleges.

While it is fairly common for teachers to keep in touch with new methods of education, we are only beginning to realize that the head nurse, too, needs to know how to teach. For this reason, the paper by Walborg Peterson, who is in charge of a medical ward, was particularly interesting. She told of her recent summer school session and the importance of principles of teaching and supervision in the preparation of the head nurse. Bernice J. Sinclair compared her first year of teaching with her second and showed how an understanding of the principles of teaching in the latter year had increased the student activity in her classes. Sylvia Perkins told how her own eyes had been opened by added courses in the subject matter of the sciences which she teaches, and Miss Bargh's paper on "Psychology and the Nurse" was most interesting in showing concrete ways in which a knowledge of the subject can help to clear up martyr complexes and other trying situations. It seemed the psychological moment for Dorothy G. Silver to explain how a $250 scholarship could be made to cover a summer-session expense, including room, board, laundry, registration, six points of college work, railroad fare and recreation; and for Adaline Chase to describe the study of scholarships and loan funds and the establishment of one at the Massachusetts General Hospital.

Anna C. Gladwin, Chairman of the Private Duty Nurses' Section of the A. N. A., spoke for the Private Duty Section and reviewed some of the problems brought out by the Grading Committee, emphasizing the fact that private duty nurses need to make more effort to be represented on boards and councils and other policy-directing bodies of hospitals and schools of nursing, in order that they may help to create attitudes toward better selection of students, since it is the private duty group which so suffers from the undesirables. She was also emphatic in pointing out that most private duty problems are peculiar to that group and must be solved by it.

Dr. M. Luise Diez, Director, Division of Hygiene of the Massachusetts Department of Public Health, spoke for the Public Health Section on "Mother and Child in a Public Health Nursing Program." The importance of education, professional and lay, in prenatal care, and the importance of the nurse in this program was stressed.

After luncheon at the Northampton Hotel, James T. Nicholson, Assistant Manager of the Eastern Area of the American Red Cross, addressed the combined groups and was followed by S. Lillian Clayton. Miss Clayton discussed "The Nurse and the Health of the Public," pointing out that the public must understand what is included in the nursing function, the need for personal fitness and professional preparation, what the content of nursing education is, and what funds and other help are needed from it. She also pointed out that the nurse's efficiency depends upon public help; that there is grave danger to the public in lack of information on its part; and that informing the public is a nursing function, the most convincing evidence for nursing being the well trained nurse at the bedside.

Following the meeting, members of the Association were guests of Miriam Curtis and the Alumnae Association of the Cooley-Dickinson Hospital at tea at McCallum Home, at which Mrs. Calvin Coolidge poured.

Minnesota: The twenty-fourth annual meeting of the MINNESOTA STATE REGISTERED NURSES' ASSOCIATION was held in Minneapolis at the new Y. W. C. A. building,

September 27–28. The Board of Directors decided on this early date so that those who desired might remain over for the meetings of the American Public Health Association, the American Child Health Association, and the Child Health and Parent Education Congress.

On Friday morning, the 27th, the Advisory Council meeting was attended by about 200, and the reports were full of interesting activities and broad interests, indicating great potentialities if directed by wise and intelligent leadership. This was followed by a business session of the State Association and a luncheon of the Board of Directors. At 2.30, the Private Duty Section and the State League each held a meeting. The Private Duty Section conducted a résumé of the papers given on "Private Duty" at Montreal. These were given by Edna V. Brown, Olive Shirley, Eunice Smith and Dorothy Biebinghauser. Kathryn McGovern reported the International Catholic Guild meeting.

At the League meeting, Stella Pines of Australia spoke on "Nursing in Australia," and Miss Gladwin on "Uses of Examination Questions." The annual dinner of the three state organizations was held at 6.30 with addresses by Anna Westley on "Our 1929 Legislation," and by Mary Gladwin

On September 28, after the general session, at the luncheon meeting of the State Organization for Public Health Nursing, Miss Pines gave a short address and Miss Lommen told of an exciting trip in Iceland on pony back

The closing business session was held in the afternoon. Officers of the Minnesota State Registered Nurses' Association are: President, Margaret Hughes, St. Paul; first vice president, Irene English, Rochester; secretary, Mrs. W. P. Rhinow, Minneapolis; treasurer, Ruth Houlton, Minneapolis; general secretary, Caroline M. Rankiellour, St. Paul.

The MINNESOTA LEAGUE OF NURSING EDUCATION elected the following officers: President, Margaret McGregor, St. Paul; vice president, Marion Vannier, Minneapolis; secretary, Maud E. Guest, Oak Terrace; treasurer, Mrs. Dorothy Kurtzman, Minneapolis; directors, Lulu Saunders, Rochester; Mrs. Pearl Rexford, Minneapolis, and Birgit Tofte, St. Paul.

West Virginia: The twenty-third annual meeting of the WEST VIRGINIA STATE NURSES' ASSOCIATION was held at the West Virginia Hotel, Bluefield, September 26–28, with about 100 in attendance. The general session on the 26th was devoted to Private Duty, on the 27th to Public Health, and on the 28th to the Superintendents' Section. Section round tables were held on the mornings of the second and third days. The program of each day was full and interesting. Major C. E Lilly of Bluefield made the address of welcome. Responses were made by Mrs. H. C. Lounsbery, Huntington; Dr. Albert Hoge, Bluefield. Other speakers were: C. W. McGinnis of the Metropolitan Life Insurance Company, who discussed annuities for nurses; Marion Bell of Fairmont, Chairman of the West Virginia Branch of the National Tuberculosis Association; I. Malinde Havey of the American Red Cross, on "Why Public Health Nursing"; J. Beatrice Bowman, Superintendant of the Navy Nurse Corps, whose address was illustrated by slides; Dr. W. T. Henshaw, State Health Commissioner, on "The Crippled Children's Council"; Major Julia C. Stimson of the Army Nurse Corps on "The Peace-Time Program of the U. S. Army"; Mrs. Andrew Wilson of the State Board of Examiners on "The Activities of the Board of Examiners and the Possibilities of Its Development." The topics discussed at the round-table meetings were varied and interesting. By way of entertainment there were: an automobile trip to East River Mountain, on Thursday afternoon; a dance on Thursday evening, given by Princeton and Bluefield nurses; a luncheon at the Woman's Club and one by the alumnae of Bluefield Sanitarium and St. Luke's Hospital, and a picnic supper. These were heartily enjoyed by all. Officers elected were: President, May Maloney, Fairmont; vice presidents, Blanche M. Young, Martinsburg, and Elizabeth White, Bluefield; W. Louise Kochert, secretary-treasurer. Fairmont was chosen as the next place of meeting.

Wisconsin: The WISCONSIN STATE NURSES' ASSOCIATION held its twentieth annual meeting, the STATE LEAGUE OF NURSING EDUCATION its fourteenth meeting, and the STATE ORGANIZATION FOR PUBLIC HEALTH NURSING its semi-annual meeting, at La Crosse, September 30, October 1 and 2, at the Methodist Church. The business meetings of the State Association were held on the mornings of September 30 and October 2, Grace Crafts presiding. Besides the annual reports of officers, presidents of districts, chairmen of standing and special committees, and delegates to meetings, reports were read from the Chairman of the 1930 Biennial Convention, Cornelia Van Kooy; the Local Arrangement Chairman, Anna Rice; and the Financial Chairman, Adda Eldredge. At the noon

luncheon, the first day, Dr. Silas Evans, President of Ripon College, emphasized the need of educators in the profession. He advocated affiliation of colleges with nurses' training schools. The afternoon of the first day, Lyda Anderson of Detroit, Mich., spoke at the Private Duty Section on "What Are the Functions of the Official Registry in the Community; Its Organization; the Type of Service To Be Expected; and Its Future?" and Janet Geister's paper on "Private Duty Nursing in the United States" was read. The same afternoon a most enjoyable ride was taken up through St. Joseph's Ridge. Before the return journey, the Sisters at St. Joseph's served a picnic supper at the top of the Ridge. In the evening a card party was given at the Grand View Nurses' Home. The second day was given over to the League of Nursing Education, Stella Ackley presiding. Routine reports were read, and Adda Eldredge gave her report as Director of Bureau of Nursing Education. Besides the general luncheon at noon, served at the Cargill Home, round-table luncheons were held for principals and assistant principals of schools of nursing and instructors and supervisors. Calvert Dedrick of the University of Wisconsin spoke on "The Relationship of Sociology to Nursing." The officers for the coming year for the League are Stella Ackley, president; Eva Barr, secretary; and Margaret Gobel, treasurer. A banquet was held in the evening at the Hotel Stoddard; the entertainment was furnished by the Seventh District Nurses' Association. While the Mendelssohn Chorus sang, a group of nurses, dressed in training-school uniforms dating from thirty years ago till the present day, paraded before the audience. The speaker at the luncheon on the third day was Miss Jones of the American Red Cross; she gave a descriptive talk on disaster work of the organization. Following are the officers of the State Association for 1929–1930: President, Cornelia Van Kooy; vice presidents, Mary Orbison, Clara Lewis; secretary, Mrs. C. D. Partridge; treasurer, Helen O'Neill. At the afternoon of the third day, given over to the Organization of Public Health Nursing, Sue W. Norman, vice president, presiding, it was voted to discontinue as a separate organization and to make application to the State Nurses' Association to become a section of that body. The address of the afternoon was given by D. Warner, Social Hygiene Lecturer, Bureau of Communicable Diseases, State Board of Health, on "Just Boys." Miss Roller, representing the *American Journal of Nursing*, was a welcome visitor at the three-day session.

District and Alumnae News

Arizona: Phoenix.—District 1 opened an official directory, October 7, at 1637 North 10 Street, with Florence Hicks as registrar. The registry is open to all Arizona state registered nurses who are members of the District. Practical nurses will also be available. All nurses coming to Arizona this winter are urged to complete their registration before arriving. The state registration fee is $10; District 1 dues are $6 a year; the registry fee is $15 a year payable in advance, or $10 for those registering after April 1, and $5 for those registering after July 1. The fiscal year begins October 1.

Delaware: Wilmington.—The Delaware Hospital Alumnae has elected the following officers: President, Emma Steptal; vice president, Anna Gibbons; secretary, Esther Petticord; assistant secretary, Estelle Lizer; treasurer, Mrs. Eleanor Clouser; and four directors.

Florida: Orlando.—District 8 has appointed Clara W. Flauss, registrar, succeeding Mrs. Studdard, who has joined the staff of visiting nurses of the Metropolitan Life Insurance Company at Daytona Beach.

Georgia: Macon.—The annual meeting of the Third District was held at the City-County Health Office, October 5, with an attendance of 38 members and five visitors. The reports of officers, chairmen of committees and of four alumnae associations were read. The secretary was authorized to order fifteen copies of the League calendar. Miss Van De Vrede, who was present, discussed the coming conventions of the Southern Division and of the State Association. After discussion of the matter, it was voted to change the name of the District from Third to Sixth, to make it correspond with the number of the Congressional District. It was also decided to raise the District registration dues from $5 to $7 for the support of State Headquarters. New rates are effective for the October, 1929–October, 1930 year. Those having re-registered at $5 a year are notified that $2 more are due the District treasury. A special feature of the program was the address made by Miss Van De Vrede, dealing with "Occupational and Professional Advancement of Women." Mrs. Foster, Superintendent of Nurses of Macon Hospital, was introduced and made welcome. Officers elected are: President, Dora E. Kershner; vice presidents, Mattie Lou Banks; secretary, Winnie B. Wood; treasurer, Ann Rogers; and three

directors. The attendance prize was awarded to Bessie Taylor.

Iowa: Council Bluffs.—Mary Kubitshek, President of DISTRICT 9, has resigned, having accepted a position at Ann Arbor, Mich. Sister M. Alberta, Superintendent of Mercy Hospital, was elected President of the NEBRASKA-IOWA CATHOLIC HOSPITAL ASSOCIATION at the closing session of its annual meeting held in Omaha early in October. Two Senior students from JENNIE EDMUNDSON HOSPITAL will be sent to the State meeting in Marshalltown. One student is being sent by the Alumnae Association, the other by the faculty and student body. **Davenport.**—ST. LUKE'S HOSPITAL ALUMNAE ASSOCIATION, for the first time in several years, is sending a Senior student to the State Convention. The hospital will send four students. A number of the members of DISTRICT 6, who reside in Davenport, attended the Illinois State meeting in Moline, in October. **Des Moines.**—The regular monthly meeting of DISTRICT 7 was held at Hotel Fort Des Moines, October 3. Private Duty Section had charge of the meeting. A discussion of twelve-hour duty for nurses was an interesting part of the program. **Keokuk.**—DISTRICT 2 regrets the resignation of Margaret Stoddard, District Secretary. Miss Stoddard has accepted the superintendency of the Skiff Memorial Hospital, Newton, Iowa, which necessitates her transfer to District 7. Mary Jane Watt, Burlington Hospital, has been appointed to fill the unexpired term. The new GRAHAM HOSPITAL building recently completed in Keokuk was thrown open to the public, October 4, 5 and 6. More than 3,500 persons were shown through the building. The walls are beautifully decorated in soft pastel tones, and well chosen drapes add a touch of color which breaks the monotony of the "all white" hospital of a few years ago. The rooms are furnished throughout with Simmons' metal furniture. The old building is being remodeled for a nurses' home.

Kansas: Topeka.—CHRIST'S HOSPITAL, in conjunction with Washburn College, is starting a college course in nursing under the name of Vail School of Nursing whereby, in five years, the students who enter will obtain a B.S. in nursing from Washburn and a certificate of nursing from Christ's Hospital, or Vail School of Nursing.

Maine: Bangor.—A class of twenty-three graduated from the EASTERN MAINE GENERAL HOSPITAL, September 26. The speaker was Mrs. Theresa R. Anderson, Secretary-Treasurer of the State Board.

Maryland: Frederick.—Citizens of Frederick County have celebrated recently the anniversary of the coming to the FREDERICK CITY HOSPITAL, twenty-five years ago, of Mary L. Nies, as Superintendent. Miss Nies had just graduated from the Reading Hospital, Reading, Pa., when she was asked to take charge of the institution, then having from two to ten patients. It is now a large hospital, with a capacity of 125 beds and with new buildings and equipment. Miss Nies received many tokens of appreciation for her tireless service from those to whom the hospital ministers.

Mississippi: Jackson.—The graduating class of 1929 of the BAPTIST HOSPITAL organized an alumnae association on July 6, with eleven charter members. The officers are: President, Mrs. T. A. Kornhaus; vice president, Elizabeth Mitchell; secretary-treasurer, Eleanor Holland; corresponding secretary, Fannie Mae Stevens. Meetings are to be held every other month.

New Hampshire: Manchester.—The ELLIOT HOSPITAL ALUMNAE met at the Y. W. C. A. rooms, on September 18, with a good attendance. It was voted to give $300 to Hazel Fuller, Superintendent of the Hospital, for classroom equipment. A contribution was also sent to a sick nurse who is a member of the State Association. Ida C. Jameson was appointed general chairman to start work on a hope chest to raise more money for the treasury. Mabel Potter gave a report of the meetings of the International Council of Nurses in Montreal. Seven members of the Association attended the meetings.

North Carolina: High Point.—The Auxiliary, the High Point Graduate Nurses' Club of DISTRICT 4, held its September meeting on the 14th at the Y. W. C. A. A large number of members was present to greet the speaker, Dora M. Cornelisen, Field Representative of the *American Journal of Nursing*, who gave a most interesting description of the *Journal* and its value to all nurses. Miss Cornelisen also spoke at several schools of nursing in High Point.

Ohio: Cleveland.—The SECTION ON PRIVATE DUTY, District 4, held a meeting, on October 9, at the Cleveland Nursing Centre. Reports from the International Council of Nurses were given. The regular monthly meeting of DISTRICT 4 was held, October 15, at Trinity Cathedral Hall. The Section on Education had charge of the program for the evening. Dr. F. S. Gibson spoke on "The

Professional Relationship between the Medical and Nursing Groups." **Massillon.**—DISTRICT 1 held a meeting, October 14, at the Massillon State Hospital. A clinic was held, in addition to the program. **Toledo.**—The regular monthly meeting of DISTRICT 9 was held in the Women's Club, September 25. V. Lota Lorimer, General Secretary of District 4, spoke on "The Advantages of an Executive Secretary for District Associations and How Financial Support Can Be Accomplished." Anna C. Gladwin, Akron, spoke on "Ten-Hour Duty for the Private Nurse." The meeting was preceded by a dinner. **Van Wert.**—DISTRICT 13 held a meeting, on September 9, at Willow Bend Country Club, with an attendance of seventy. Dr. H. M. Austin spoke on "Tuberculosis." Marion Kahled read a paper on "Music and Its Origin."

Pennsylvania: Erie.—ST. VINCENT'S HOSPITAL held graduating exercises for a class of twenty at the Villa Maria Auditorium, October 14. **Philadelphia.**—The FIRST DISTRICT ASSOCIATION met September 20; the program was in charge of the Private Duty Section. S. Lillian Clayton gave a lucid and interesting account of the Harmon Annuity Plan and also a delightful talk on "Private Duty Nursing in Foreign Countries." Interest in recent demonstrations of modern nursing procedures given by the District Association indicate that demonstration classes would be welcome. Alumnae Associations were asked to send contributions of news to the Committee on Education and Publicity for publication in the *American Journal of Nursing* and *Penn Points*. **Pottsville.**—DISTRICT 2 held its regular meeting, September 21, at the Nurses' Home of the Pottsville Hospital, with a large attendance. Reports from the International Council of Nurses were given. **Pittston.**—DISTRICT 3 held its regular meeting, on September 19, in Pittston Hospital, with an attendance of sixty-five. It was an enthusiastic meeting. A very instructive lecture in Pediatrics was given by Dr. Rubenstein, a staff member of the Pittston Hospital.

Deaths

Jean Gibb (class of 1910, Jefferson College Hospital, Philadelphia) at her home in Susquehanna, Pa., on October 3, after a brief Illness. Miss Gibb was engaged in private duty in Philadelphia from the time of graduation until death, and her entire life was devoted to unselfish service for others. She was a loyal and faithful nurse, a true and sincere friend; she will be missed by all who knew her.

Catherine Holehouse (class of 1912, St. Joseph's Hospital, Milwaukee, Wis.) on September 23, at St. Mary's Hospital, Wausau, Wis., after a long illness. Burial was at her home, West Bend, Wis. Miss Holehouse had held many responsible positions, being superintendent at St. Joseph's, Ottumwa, Iowa, from 1914 to 1917, also Superintendent at St. Alexius Hospital, Bismarck, N. D., from 1921 to 1923, and for the last four years Superintendent at St. Mary's Hospital, Wausau, where she was at the time of her death. Miss Holehouse was loved and admired by all who knew her.

Marguerite C. Kelly (class of 1914, Metropolitan Hospital, Welfare Island, N. Y.) on September 17, in New York City, following an operation. After graduating, Miss Kelly did Board of Health nursing in New York until she went to France in June, 1917. She was with the Presbyterian Unit in France until February, 1919. On her return to New York, she did Social Service work in the City Department until she received her appointment as Superintendent of Nurses of Central Neurological Hospital, Welfare Island, Department of Public Welfare (since changed to Cancer and Neurological Hospital, Department of Hospitals) in October, 1920. Although Miss Kelly was but thirty-five years old at the time of her death, she led a very active life in different nursing organizations. She was Past-President of the Catholic Nurses Club, Past-Commander of the Jane A. Delano Post of the American Legion. At the time of her death she was Chairman of the Publicity Committee of District 13, and was made Secretary of International Catholic Nurses' of America in 1929. The Red Cross has also lost one who was always interested and ready for coöperation. She was buried with military honors.

Elizabeth A. MacDermott (graduate of St. Joseph's Hospital, London, Ontario, Canada) on August 9, of pernicious anemia, at the Home for Incurables, New York. Miss MacDermott did private duty nursing for twelve years prior to 1918, when she joined the Army Nurse Corps and served overseas with Base Hospitals 8 and 9 until November, 1918, when she resumed private duty nursing for a period of nine years more. When she became ill, she was cared for at the Presbyterian Hospital, Medical Centre, for eight months. Burial was at Arlington.

Flora B. MacRae (class of 1887, Boston City Hospital) on September 9, after a brief illness, at the Nurses' Home, Metropolitan Hospital, Welfare Island, N. Y., at the age of seventy-four. The members of the first class of Johns Hopkins Hospital will remember her as Head Nurse of Wards D and E, 1889–1890. From Johns Hopkins she went to Hartford, Conn., to become Superintendent of Nurses at the Hartford General Hospital. Later she spent seven years as a missionary nurse in China, and upon her return to the United States specialed in the Private Pavilion of the Presbyterian Hospital, New York. Later she became Night Superintendent of the New York Ophthalmic Hospital. Fifteen years ago, she took the position of Night Superintendent at the Metropolitan Hospital, which she held until her death. Services were held in the Library of the Nurses' Home, conducted by the Episcopal chaplain of the hospital. A beautiful eulogy was given by the resident Rabbi, who had known her for some years, and who spoke of her wonderful work, rare attainments and culture.

Alma Kinne (class of 1921, Lutheran Hospital, Hampton, Iowa) on October 5, at the Atlantic Hospital, Atlantic, Iowa, following an operation. Miss Kinne had recently completed a course at the Northwestern Institute of Technology, Minneapolis. Miss Kinne had held positions in Sturgess, Mich., Harvey, Ill.; Boone, Iowa; and Atlantic, Iowa. By her high character, loyalty and devotion to her profession, Miss Kinne made many friends, all of whom will mourn her loss.

Elizabeth C. Lewis (class of 1887, Philadelphia General Hospital, Philadelphia) in Chicago, Ill., suddenly, while visiting a sister. Miss Lewis had been living in the far West for some years.

Meta Miessner (graduate of the Ladies of the Lord Sisters' Hospital, Hot Springs, S. D.) at Hagin and Gregory Hospital, Miller, S. D., on October 2, of meningitis, after an illness of three days. Miss Miessner had done many years of successful nursing in South Dakota, as well as in several other states. She had held a position in the hospital, where she died, for the past four years.

Nellie May Rennyson (graduate of the Protestant Episcopal Hospital, Philadelphia) suddenly, on July 6. Miss Rennyson was a chief nurse at the Philadelphia General Hospital for some years and was an honorary member of the Alumnae Association. During the early part of the World War she gave preparedness talks, and she was in active service at Camp Meade and Camp Dix. Burial was at Norristown, Pa.

Nellie C. Smith (class of 1903, Crawford Sanitarium, Memphis, Tenn.) on September 21, at her home in Memphis. Miss Smith was registrar of the central directory in Memphis until last January, when she resigned because of ill health. She was a member of the local Red Cross Committee and of the state and district associations. The members miss her. She is a great loss to her profession.

Eileen E. Sward (class of 1907, St. Joseph's Hospital, Sioux City, Iowa) on August 11. Following graduation, Miss Sward practiced as a private duty nurse in Omaha. She enlisted in the Army Nurse Corps in 1918 and was assigned to Camp Pike, Arkansas. Later she entered the U. S. Public Health Service and the U. S. Veterans' Bureau. At the time of her death she was on duty at U. S Veterans' Hospital. Northport, Long Island, N. Y.

Lydia Whiton (class of 1890, Philadelphia General Hospital, Philadelphia) on August 19, at her home, Hingham, Mass. Miss Whiton served as a head nurse at the Philadelphia General for some years, then went to the University of Pennsylvania Hospital, and finally to Meadville, where she was Superintendent of Nurses of the Meadville City Hospital for thirty years. Miss Whiton was known and loved by many, she had the confidence and affection of the entire community of Meadville.

Florence Hoff Yeiter (class of 1904, Philadelphia General Hospital, Philadelphia) on June 18, at the U. S. Veterans' Hospital, Outwood, Ky. Miss Yeiter was a private duty nurse in Atlantic City until she enlisted for service during the World War. She served at Camp Wheeler, Macon, Ga., and at the Debarkation Hospital, New York. At the close of the war she entered the service of the U. S. Veterans' Bureau, having been a Chief Nurse for seven years. Burial at Millville, N. J., was with military honors. Miss Yeiter was a faithful nurse and a true friend.

Questions

Is it wise to have two registrars, on a fifty-fifty basis, equals in everything?

Answer.—There should not be two registrars or heads on a fifty-fifty basis, operating in the same registry. A registry should be run as we run every other office; whether it be in a hospital or in a mercantile establishment. *One* person must be responsible for the administration. A registry that has two people of equal power at the head can function just as well as a hospital or a business that has two people of equal power and responsibility trying to run it.

The best form of registry organization that we know of today is the one that is under the supervision of a director. She is responsible not only for answering calls, but it is her responsibility to analyze the accomplishments of the registry, and to build up a positive program for advancement. Under her direction, work the registrars who place the calls and carry on the routine work of the registry.

The director of a registry should be responsible to a board or committee. This committee may be a "mixed" committee, representing the community, hospital, medical profession, as well as the nursing group. There is a distinct trend in that direction. Or it may be a committee made up of every branch of nursing, with a "mixed" advisory committee. The director should report to this group once a month, and it is this group that formulates the policies of the registry.

To repeat, there should be only one head to a registry, as in any other business, if the registry is to function with any degree of efficiency and harmony.

JANET M. GEISTER, R.N.
Director at Headquarters,
American Nurses' Association.

The Directress of Nurses is wearing the school cap of one of our traditional schools. We know that she has no right to do so. What are the ethical standards regarding school caps? What will be the reaction of her students when they know that this cap does not belong to her? After four months of hard study a cap will not mean much to them if their executive head can put on another school's cap because it may give her a little more dignity and prestige. We feel that this person is not ethically fitted for such an honorable position. What do the JOURNAL *and its readers think about it?*

Answer.—The graduate cap of a school of nursing is a precious possession, to be worn only by those who have won the right to do so, viz., by those who have been graduated by the school and who are in possession of its diploma. It is protected by the idealism of nurses and not by law. The nurse who wears the cap of a school from which she was not graduated may be doing it merely from vanity, and because she thinks it becoming. Actually, she is more than vain, she is dishonest, for caps are quite generally accepted as an outward symbol of professional preparation. It is not to be wondered at that the caps of some of our well known schools are coveted by the less fortunate. The fact remains that an honorable woman wears one only if she has acquired it by graduation from the school in question.

Caps and uniforms are easily changed and modified. The school pin has come to be the one unchanging symbol of many schools. Nurses usually know when cap and pin are in accord. The assumption of a cap to which the wearer is not entitled is a silly pretense and one of which a clear thinking and honorable person would not be guilty.

Some schools have an undergraduate cap and a graduate cap. Student nurses look forward with eager pride to Capping Day and again to Commencement Day. It is extraordinary that any person in a position of authority would do aught to lessen in any way the significance of the symbolism of the cap.

About Books

MEDICINE: ITS CONTRIBUTION TO CIVILIZATION. By Edward B. Vedder, A.M., M.D. 398 pages. The Williams & Wilkins Company, Baltimore, 1929. Price, $5.

THIS volume should have value in nursing school libraries where an effort is being made to teach preventive as well as curative medicine. It is written in popular style. Diseases, classified as transmissible, nutritional, of endocrin origin and degenerative, are dealt with largely from a public health standpoint. In his description of individual diseases, the author includes cause, pathology, symptoms and mortality rates and stresses preventive measures, which can hardly be urged too strongly.

A strong appeal is made for regular health examinations, the correction of remediable defects and the application of the principles of personal hygiene.

There is a history of the development of preventive medicine, a description of the present-day application of preventive measures and the resultant saving of life and increase in longevity.

The section on "Modern Preventive Medicine" gives much information on the official and unofficial public health agencies of the United States.

THE CHILD'S HEREDITY. By Paul Popenoe. 304 pages. Illustrated. Williams and Wilkins Company, Baltimore. 1929. Price, $2.

POPENOE'S "Child's Heredity" could scarcely be classed as a text, because the material covers such a wide range of subject matter. But for use as a reference for a class in psychology, sociology, mental or social hygiene or eugenics, this book would enlarge any student's vision and prove a valuable aid in orienting the student whether the field be that of the biological sciences, philosophy or nurse-education. As a book of general interest, its value and challenge to the reader would depend largely upon whether the individual had any special or general knowledge of the biological sciences, or of normal or abnormal psychology.

The author says in his preface that the book is "a guidebook for parents" and that "their interests and practical needs have determined the selection, arrangement and treatment of material." Some of the discussion in Chapter II on "The Child's Relation to His Ancestors," concerning the mechanism of cell division in the germ cells is rather too technical unless the parent has more than a superficial understanding of biology. This material might be more valuable to a greater number of parents, if given in less purely scientific terms. In Chapter XXII, "Diseases of the Mind," there are a number of terms used which, if carefully defined, for the lay individual might impart valuable fundamental information and carry considerably more meaning.

The book should certainly prove very stimulating to any person, whether lay or professional, in enlarging his general field of knowledge. It should bring to his attention the fact that no science is isolated, but that all the

sciences have their points of contact—for example, the student of psychology, or of social or mental hygiene, to have a sound basis for his knowledge of his special subject, must understand something of the biological sciences and of the abnormal mind.

The references are carefully listed so as to make them easily accessible to the reader who wishes to investigate any phase of this subject further. The illustrations too are well chosen, since they clarify points in the text which might otherwise be difficult to understand or visualize.

MARION J. FABER, R.N.
Illinois.

THE HEALTHY BABY. By R. H. Dennett, M.D. New edition, revised, with new matter. 247 pages. The Macmillan Company, New York. Price, $1.25.

IT is much easier to prevent an illness than it is to cure one. With this fact in mind, the author aims to make clear to the mother just how to do best the ordinary everyday things that every mother has to do for her child.

Considerable stress is laid on the importance of establishing regularity in the child's daily routine. About one-third of the book is given over to feeding and diet and related subjects. Diets for older children and sick children, as well as infant feeding, are discussed. Some of the new points taken up in this revised edition are the use of sunlight, the ultra-violet ray, and cod liver oil in the prevention and cure of rickets, and the use of liver as a cure for anæmia.

A helpful, brief section on training, discipline, and habit-formation is given in the first part of the book. There are sections also on the care of the special organs, and on common ailments.

Fifteen pages are reserved for memoranda, including the weight of the child up to ten years, the record of the baby's food, record of physical developments, health record, teething record, and additional items which the mother may choose. A helpful index is also included.

ANNA HEISLER, B.S., R.N.
New York.

NURSING IN EMERGENCIES. By Jacob K. Berman, M.D. 160 pages. Illustrated. The C. V. Mosby Company, St. Louis. 1929. Price, $2.25.

HERE are set forth with clarity very sound ideas of the nurse's rôle in emergencies when a doctor is not immediately available. The book encourages a habit of thought which will enable a nurse to weigh the wisdom of certain procedures and will help her to think beyond the confines of hospital service. There are many helpful suggestions for coöperation and for acquiring a quick reaction to emergencies, while the illustrations are simple and practical and show such procedures as nurses are called upon to use in emergencies.

ELIZABETH SHERWOOD
Maryland

PATHFINDERS. By Adah B. Thoms, R.N. 240 pages. Illustrated. Published by the author, 317 West 138th Street, New York. 1929. Price, $2.50.

"THESE pages," says the author of this interesting account of the strivings of colored nurses, "are but the 'makings' of a more complete story of the progress of colored nurses which must be written in words and in deeds by the young nurses who are to come after us."

About one-half of the book is devoted to the better known schools for colored nurses and their graduates. The biographical sketches make espe-

cially interesting reading, for it is through the struggles of those oft-times heroic women that professional standards in nursing may one day be generally achieved by colored nurses.

Suitable space is given to the nurse in public health, in Red Cross work, in the mission field, and to the National Organization. In "A Glance at the Future" the author expresses the aspiration of her race as follows:

> Racial progress through the instrumentality of the nurse lies, it seems to me, in two directions. Our first approach is in the improvement of our existing schools of nursing and of the quality of our applicants—for new professional heights cannot be scaled without knowledge.

REFERENCE HAND-BOOK FOR NURSES. By Amanda K. Beck, R.N. Sixth edition, revised. 316 pages. W. B. Saunders Company, Philadelphia, Pa. Price, $1.50.

Adelaide Nutting and Lavinia Dock Prize

For an Historical Essay Dealing with a Nursing Subject

IN honor of these two pioneer writers of nursing history, a prize of one hundred dollars has been offered for the best historical essay submitted by a student or graduate nurse, before January 1, 1931. The conditions are as follows:

1. The subject must be one which is directly concerned with some important phase of nursing history.
2. The essay must show original research by the writer.
3. The essay should cover from 8,000 to 10,000 words and should be typewritten.
4. There should be a cover page with full title, a table of contents, and a brief outline of the subject matter of the essay.
5. The essay should be fully documented with footnotes and should include a detailed bibliography.
6. The language used should be English, French or German.

Any student or graduate nurse wishing to enter the contest should write to the chairman of the History of Nursing Committee, Miss Nina Gage, 370 Seventh Avenue, New York City, giving her name, address, professional training, and experience, and two references. Each registered contestant will then receive a number which she will place on the essay instead of her name. Her name and number should be enclosed in a sealed envelope accompanying her paper, and the whole should be insured if sent by mail.

The judges will make their decision on the basis of:

1. The worth of the material.
2. The sources consulted.
3. The form of the paper.
4. The clarity and originality of the presentation.

Books You Will Enjoy

ISABEL ELY LORD

AFRICA seems to be the part of the East that people hear calling now—though not with the tinkly temple bells. *Then I Saw the Congo*, the "I" being Grace Flandrau, is an enthralling book. The author can write as well as see, and the many illustrations are of the best—taken with a moving picture camera, and admirably reproduced. (Harcourt, Brace, $3.50.) A far finer volume, with some of the illustrations in color, is *White Africans and Black*, by Caroline Singer and LeRoy Baldridge. (W. W. Norton, $10.) The text is not to this reviewer, at least, as fascinating as that of Miss Flandrau—but mighty interesting, all the same.

One of the most stimulating types of biography is that which tells of the development of some man who grew to be eminent in his special field. Such a book is *The Early Life of Thomas Hardy, 1840-91*. It contains many excerpts from his notebooks and his diary, and a few letters. These are woven into a narrative by his widow, Florence Earle Hardy. It is a fine volume to read a little at a time. (Macmillan, $5.)

If you are looking for guidance for the reading of children, probably you already know *The Three Owls*. Here is a second series. Each volume is made up of selected reviews that have appeared in the "Books" of the New York *Herald-Tribune*, on the Three Owls' page, edited by Anne Carroll Moore. Miss Moore has written some of the reviews, edited them all. The volume is very interesting reading for grown-ups, and invaluable for those who have to find books for children of any age. There are delightful illustrations. (Coward, McCann, $3.)

Eagles Fly High, by E. B. Dewing, is a worth-while study of a girl with poor background, fine talent, and no real desire for marriage. It has a sad ending—yet not one that is a failure on the part of the heroine. (Stokes.)

Of *Joshua's Vision*, W. J. Locke's latest, many will say, "That doesn't sound a bit like Locke." It is less cynical, perhaps less amusing, than most of his novels, but interesting and entertaining none the less. (Dodd, Mead.)

In *October's Child*, Donald Joseph has given us an unusual novel—the story of the development of a boy of sensitive temperament from the time he is six to his freshman year in college. There is no real love story in it, in the ordinary sense of the term, but much of the boy's love for his mother and his college chum. It is well worth reading. (Stokes.)

The Strange Companions of whom John Cranstoun Nevill tells are old grandmother and young grandson, of an old shipbuilding family of England. The story covers the World War, but not directly—only its effect on the family. The book has great charm. (Little, Brown.)

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